

**DEPARTMENT OF VETERANS AFFAIRS
BUDGET REQUEST FOR
FISCAL YEAR 2006**

HEARING

BEFORE THE

**COMMITTEE
ON
VETERANS' AFFAIRS**

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2006

WEDNESDAY, FEBRUARY 16, 2005

HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The Committee met, pursuant to notice, at 10:08 a.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer, [Chairman of the Committee] presiding.

Present: Representatives Buyer, Evans, Bilirakis, Filner, Brown of Florida, Moran, Baker, Michaud, Brown of South Carolina, Herseth, Miller, Strickland, Boozman, Hooley, Berkley, and Udall.

THE CHAIRMAN. The full Committee on Veterans' Affairs will come to order on February 16, 2005.

We would like to welcome everyone to the first official hearing of the 109th Congress, which is testimony on the Department of Veterans' Affairs budget request for fiscal year 2006.

Our first witness is the Secretary of Veterans' Affairs, the Honorable R. James (Jim) Nicholson, the Secretary nominated by the President on December 9, 2004. He was unanimously confirmed by the Senate on January 26, 2005, and he took office on February 1, 2005.

Today is February 16th. So in 16 days, he should have all the answers today. Mr. Secretary, we welcome you.

I would now like to recognize Mr. Evans for any opening statement that he may have. Mr. Evans?

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, COMMITTEE ON VETERANS' AFFAIRS

MR. EVANS. Thank you, Mr. Chairman.

This budget submitted to us on February 7th is one of the most dishonest and insensitive documents I have seen in over two decades in Congress.

The administration's budget not only severely shortchanges the nation's sick and disabled veterans, it seeks to force hundreds of thousands of deserving veterans out of the VA health care system and to

abandon its long-term care obligations. This will force the Department of Veterans' Affairs to sustain and even broaden the practice of rationing care to veterans that has been a hallmark of this administration.

The bottom line is this, this budget is at least \$3.2 billion short in discretionary funding just to keep the VA shop afloat without forcing one veteran to pay for another veteran's health care.

The administration wants to put a financial burden on veterans seeking care. We cannot accept this.

The administration intends to weaken the VA health care system through a staff reduction of more than 3,000 health care professionals, mostly nurses. We can't accept this.

The budget proposal would eviscerate VA's nursing home program and state home nursing programs. We must not accept that, either.

Under the Bush budget, there are no new initiatives to improve the administration of benefits to veterans. This is inexcusable.

I want to thank the veterans organizations that put together an independent budget. I want to thank those organizations who will testify later today. And I want to thank Secretary Nicholson. We look forward to your testimony.

Thank you, Mr. Chairman.

[The statement of Hon. Lane Evans appears on p. 58]

OPENING STATEMENT OF CHAIRMAN BUYER

THE CHAIRMAN. Thank you, Mr. Evans.

Mr. Secretary, I'm glad you could be with us here today to share with the Committee the President's proposed budget for 2006.

Those of us on this Committee take very seriously our responsibility to ensure that the VA provides the highest quality health care for those who are enrolled now and those who will be enrolled in the future. We are honored by the trust placed in us by our respective caucuses. Capitol Hill can be a very partisan place. Sometimes we can also hear the politics of extreme, not only by members but perhaps even worse, by some organizations that associate themselves here in the Capitol.

When we walk through this hearing room door, our effort is to leave the partisanship aside. That does not mean we will always agree. We do not. We communicate, and sometimes it is hard, but we work together so that we can provide the best possible services to those who have left freedom in their footsteps. Our guiding principles are no different than those who serve.

Last Friday I had an off-site meeting with many of the veteran and military service organizations in Charleston, South Carolina on the campus of the Citadel.

I took with me the Subcommittee Chairman, and the staff direc-

tors. We met with the top ten of the veterans service and military service organizations.

We discussed how and where each participant who has served in the military took the oath of enlistment or of commissioning.

The Vice Chairman of this Committee, Mr. Bilirakis, I'm sure can also remember where he took his oath for the Air Force. I am also quite certain that, Mr. Brown, you can remember where you took your oath for your enlistment in the South Carolina National Guard. I'm also quite certain it is true for Mr. Evans on where he took his oath in the United States Marine Corps, or Corporal Vic Snyder, who took his oath before he was shipped out to Vietnam with the United States Marines.

Service in the Armed Forces does not make one person more patriotic than another. Actually, I have always found that offensive. We all serve this country in many different ways and many different capacities, and we all in an effort to do it with selfless service.

One might have a father who served and now works on behalf of veterans at a veterans' hospital or a veterans' service organization, where they volunteer in some capacity to help a veteran.

Another may not have served in the military but they also serve here in Congress. They serve on the congressional staffs here for the Veterans' Affairs Committee.

Mr. Secretary, I'm sure you have many loyal employees who work in your administration, many of whom perhaps never served in the military, but, because of their intent, their service I don't believe is much different from those who had served.

I hope in your opening, I'm quite curious, I'd like to know where you took your oath. You went to a military academy. You took one there. You also took another one upon your commissioning.

Those of us who have been instilled with certain values, we call them our military values. In the Navy and Marine Corps, it is honor, courage, commitment. In the Army, it's loyalty, duty, respect, service, honor, integrity and courage. In the Air Force, it's integrity first, service before self, excellence in all we do. In the Coast Guard, it is honor, respect, devotion to duty. In the Merchant Marine, it is integrity from within, respect for others, courage in diversity, and service above self.

On Friday at the retreat in Charleston, we all agreed that these are the same values for which we serve now and will define our commitment to care for those veterans with Service-connected disabilities, those with low incomes and those with special health care needs.

It is our job to receive this budget today, to listen and learn about how this administration seeks to better the VA and ensure that our health care resources continue to be concentrated on care for the enrolled veterans most in need of VA services.

To make certain that our research continues to push the bounds

of science in prosthetics; to have a seamless transition from DOD to VA to provide for timeliness of compensation and pension claims, and also to make sure that they are accurate and consistent; and to make sure that those men and women who come back receive not just governmental assistance, but receive an opportunity to live and to raise their quality of life above a paycheck.

Mr. Secretary, several weeks ago, we met and discussed these very same issues. We talked about how our role is not to provide just governmental assistance. Many of us have been to Walter Reed and Bethesda.

I know firsthand the significant challenges those men and women face. Some of them need mental health care. Some may need physical therapies. Some will need to learn to walk or to learn even how to throw a ball.

We stand in amazement at their sacrifice and those willing and eager to join back with their unit, even though they have disabilities. For those who cannot go back but instead go home, it is our job to make sure they have the ability to go home and be productive members of society and to live their lives, to have every opportunity to succeed.

Mr. Secretary, I note from our conversation that you will join Mr. Evans, this Committee, and me in this endeavor to make the VA the best it possibly can be.

I thank you again for your service to country, both as an Army Ranger, not only for your service in peace but also in war. I also thank you for your service to this country as ambassador to the Vatican and for answering the call of this President to serve as the Secretary of Veterans' Affairs.

We look forward to hearing your testimony today, and we look forward to working with you in the future.

Mr. Secretary, if you would begin by introducing the staff who is accompanying you at the table, and then you may proceed with your opening statement.

STATEMENT OF THE HONORABLE R. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY: JONATHAN B. PERLIN, M.D., ACTING UNDER SECRETARY FOR HEALTH; VICE ADMIRAL DANIEL L. COOPER, U.S. NAVY (RETIRED), UNDER SECRETARY FOR BENEFITS; RICHARD A. WANNEMACHER, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS; TIM McCLAIN, GENERAL COUNSEL, RITA A. REED, DEPUTY ASSISTANT SECRETARY FOR BUDGET

SECRETARY NICHOLSON. Thank you, Mr. Chairman. It is a pleasure for me to introduce my colleagues at this table.

I will start with the gentleman to my far left, who is Tim McClain, who is General Counsel for the Department of Veterans Affairs. To my immediate left is Dr. Jonathan Perlin, who is the Acting Under Secretary of the Veterans' Health Administration.

To my far right, Dick Wannemacher, who is the Acting Under Secretary for The National Memorial Administration. Coming this way is Admiral Dan Cooper, who is the Under Secretary for Benefits for the VA, and on my immediate right is Ms. Rita Reed, who is the Deputy Assistant Secretary for Budget.

Mr. Chairman and members of the Committee, it is a pleasure for me to be here today. It is the first time I've had the opportunity to appear before you. I have now been in this job - this is the third day of my second full week. As you will see, I have not become an expert in every aspect of this vast and wonderful organization, I will assure you and probably make obvious to you.

It is a tremendous privilege for me to have the opportunity to be serving my fellow veterans and my country men in this capacity with this responsibility at this time.

Mr. Chairman, I do remember when I took my oath. I grew up in a town of 99 people in Northwest Iowa. I got a telegram by Morse Code. I'm not as old as Abe Lincoln, but it sounds like that. I did. It said I was admitted to West Point.

I headed out, went to New York City from a town of 99 people way up the Hudson River. On July 2, 1957, I took my oath and was sworn in as a member of the Corp Cadets and then was commissioned on June 7, 1961, where I also took my oath as a commissioned officer. It was the best thing that ever happened to me in my life.

I would ask that my written statement be submitted for the record and that I be allowed to offer some brief remarks.

THE CHAIRMAN. Without objection, it will be entered.

[The statement of Hon. R. James Nicholson appears on p. 72]

SECRETARY NICHOLSON. Mr. Chairman and members of the Committee, for the better part of a year, health care, benefits, and burial experts at the Department of Veterans' Affairs have worked closely with the President's team to assess the VA's future resource needs.

Their goal was to ensure that VA continues to care for those veterans who count on us the most. The President's fiscal year 2006 budget proposal for \$70.8 billion meets that need. \$37.4 billion is proposed for entitlement programs, and \$33.4 billion for discretionary programs.

This total represents a 2.2 percent increase over the fiscal 2005 enacted level.

The discretionary funding level would represent an increase of \$880 million or 2.7 percent over the enacted level for 2005.

The proposed mandatory spending level represents a \$639 million

or 1.7 percent increase over the 2005 level.

When compared to the fiscal year 2001 enacted budget, this budget represents a total increase of about 47 percent in medical care funding, with a 44 percent increase in discretionary funding alone.

The President's 2006 proposal will allow us to do the following: meet the health care and benefit needs of all newly separated veterans of the conflicts in Iraq and Afghanistan. Maintain the high standards of health care quality for which the VA is now nationally recognized, while treating over 5.2 million patients, about one million more patients than in 2001.

It will allow us to follow through on a historical realignment of our health care infrastructure, reduce the backlog of disability compensation and pension claims, and continue the largest expansion of the national cemetery system since the Civil War.

In the health care field, in recent years, the Department's successes in delivering top notch health care have been stunning. The VA now exceeds the performance of private sector and medical care providers for all measurable key health care quality indicators.

This is all the more impressive when you consider the explosive growth in VA health care usage.

The VA expects to treat about one million more patients in 2006, for a total of 5.2 million then was done in 2001.

The President's 2006 budget asks that you enact two important provisions affecting only Priority 7 and Priority 8 veterans, an annual enrollment fee of \$250 and an increase in the pharmacy co-payments from \$7 to \$15 for a 30 day supply of drugs.

The proposed enrollment fee is similar to the fee legally required of military retirees enrolled in the TRICARE system, and some would argue even more justified.

As you know, most TRICARE enrollees have served on active duty for at least 20 years, and are former enlisted personnel with modest retirement incomes.

The proposed enrollment fee would affect those veterans who may have served as few as two years and who have no Service-connected disabilities.

In addition, some of these veterans, those in Priority Group 8, have incomes above the HUD geographic means test.

This budget proposal also ensures the following highest priority veterans receive the long term care they need -- those injured or disabled while on active duty, including veterans who served in Operations Iraqi Freedom and Enduring Freedom, those catastrophically disabled, patients requiring short term care subsequent to the hospital stay, and those needing hospice or respite care.

These eligibility criteria would be applied to VA sponsored long term care services, including VA, community and state nursing homes. This would save approximately \$496 million that would be

redirected toward our high priority veterans.

The Department would continue to expand access to non-institutional long term care with an emphasis on community based and in home care. In many cases, this approach allows veterans to receive these services in comfortable, familiar settings of their homes surrounded by their families.

In order to be more prepared to care for our veterans returning from OIF and OEF, VA's 2006 medical care request includes \$1.2 billion, which is \$100 million over the fiscal year 2005 enacted level, to support the increasing workload associated with the purchase and repair of prosthetics and sensory aides to improve veterans' quality of life, and includes \$2.2 billion or \$100 million over the 2005 level to standardize and further improve access to mental health services across the system.

We are also proposing a number of program enhancements to cover out of pocket costs for emergency care that veterans receive at non-VA facilities, to exempt former POWs from co-payments for VA extended care services, and to exempt veterans from co-payments for hospice care delivered in hospitals or at home.

We have projected increased health care management efficiencies of two percent in 2006, which will yield about \$600 million in savings.

The \$750 million requested for CARES, Capital Asset Realignment for Enhanced Services, in fiscal 2006 is \$172 million more than the 2005 enacted level. At its core, CARES means greater access to higher quality care for more veterans closer to where they live.

Its impact is already being felt in Chicago, where the proceeds from an enhanced use lease of VA's Lakeside Hospital property are being reinvested in the VA's Westside facility. This will lead to a new modern bed tower for Chicago's veterans.

Finally, the \$786 million proposed in support of VA's medical and prosthetic research program would fund about 2,700 high priority research projects to expand knowledge in areas critical to veterans' health care needs.

The combination of VA appropriations and funding from other sources would bring our 2006 research budget to nearly \$1.7 billion.

Veterans' benefits. The President's request includes \$37.4 billion for the entitlement costs mainly associated with all entitlement benefits. Our request also includes \$1.26 billion for the management of the Department's benefits programs, which is a 6.6 percent increase over the 2005 enacted level.

The VA takes seriously its obligation that every veteran's claim must be treated fairly and equitably. We must be consistent.

Our Inspector General has been directed to conduct a review of our disability claims adjudication process. The results will identify areas of inconsistency, and will help us formulate steps to remove to

the maximum degree possible inconsistencies which obviously exist today in a difficult, complicated process.

In addition to this independent system wide review, the Veterans' Disability Benefits Commission has been established to carry out a study of the statutory benefits that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to their military service.

The President's request would also permit us to continue the benefits delivery at discharge or BDD program. This program enables active duty Servicemembers to file disability compensation claims with VA staff at military bases, complete their physical exams there, and have their claims evaluated before or closely following their military separation.

The President's 2006 budget includes \$290 million in discretionary funding for VA's burial program, which includes operating and maintenance expenses for the National Cemetery Administration, its capital programs, the administration of mandatory burial benefits, and the state cemetery grants program.

This total is nearly \$17 million or 6.4 percent over the 2005 enacted level. It includes \$90 million for cemetery construction projects.

Consistent with the provisions of the National Cemetery Expansion Act of 2003, we are also requesting \$41 million in major construction funding for land acquisition for six new national cemeteries and \$32 million for the state cemetery grants program.

We believe veterans should have the option to be buried in a veterans' cemetery located within 75 miles of their home. More than 80 percent will have that option under this budget proposal.

Mr. Chairman, I would be remiss if I did not note that last year VA's National Cemetery Administration earned the highest rating ever achieved by a public or private organization in the 2004 American Customer Satisfaction Index. It was a rating of 95 on a scale of 100.

In closing, Mr. Chairman, despite the many competing demands for Federal funding, the President continues to make veterans' benefits and services a top priority of his Administration.

Mr. Chairman, our veterans deserve no less.

We are now prepared to take your questions. Thank you.

THE CHAIRMAN. Thank you, Mr. Secretary. I have several questions. One will focus on seamless transition. I'd like to know what the Department is doing to ensure that Operation Iraqi Freedom and Operation Enduring Freedom servicemembers are identified and provided with the benefits they deserve.

I recognize what you just mentioned with regard to the one exam and determinations upon discharge. We are hopeful that will lead to greater accuracy and timeliness in these determinations.

I would like for you to answer that in greater detail.

I would also like for you to touch on CARES and even outside of CARES, with regard to competitive sourcing. I'd like your input on that.

I would also like you to talk about the third party collections.

I know we have a pilot project out there. Unisys received the bid on that contract. It is in Ohio. I've been concerned about the growth of that contract and whether we need to have another competitive pilot. I would like your comments with regard to that.

It is how we perfect the health system, whereby we do everything properly, from the first sign when the patient walks in, getting the necessary information, having the right codings, the doctors doing their jobs. We have to follow through the system. That is quite an investment.

The other comment I would like you to make is with regard to - we are going to give you some running room -- with regard to IT. I'm hopeful that you will come up with a proposal for the Committee with regard to how you can restructure IT so that your chief information officer has line and budget authority.

We have been very concerned over the years on how much money we have been authorizing and appropriating here in Congress with regard to IT, and you have three stovepipe systems. We believe that if you are able to empower with budget authority your CIO, we can save money in the end.

My last comment will be that I appreciate your highlighting the inequity that we presently have. When I offered TRICARE for Life and that passed, we instituted these co-pays and deductibles, and now when you have a situation whereby a VA hospital may be a TRICARE provider, you are absolutely correct, you could have somebody, having only serviced for one tour of duty, go in just before that military retiree and he doesn't have to pay the deductible, when in fact the military retiree does.

We have an inequity in the system that we are going to need to address.

I yield to you, Mr. Secretary.

SECRETARY NICHOLSON. Thank you, Mr. Chairman.

Let me start with the seamless transition. That is a very high priority in our agency, because we have to get it right. These people returning from Iraq and Afghanistan deserve no less. We have a senior individual in the agency who is our seamless transition guru, if you will. All of us are collaborating on that.

I think great progress has been made. We have stationed VA representatives in some cases with returning units. We have put people on aircraft carriers to help orient and process people on their way home from deployment.

We have people at all the major medical facilities. We have people in Gruenstadt, Germany.

The goal is to impart good information and take the hassle out of the process for this person on active duty about to become a veteran, about to become an alumni of active service and become one of us, a veteran.

I feel pretty good about the progress that is being made. I've conferred with Secretary Rumsfeld. We are working closely with the DOD on that. That, I think, is moving as it needs to. It is a priority.

The CARES process is very commendable. It addressed a need there is out there to bring the Department of Veterans Affairs into the 21st Century. As you all know, most of the hospitals in stock were built to serve World War II returnees. The average age was over 50 years. The average age of a hospital in a civilian component today is about ten years. That is an issue. Another is some of our hospitals are not ideally located, given the demographic shifts of our country.

CARES addressed that and the general inefficiencies that are ensured from this aged hospital and facility stock. We are now under-way.

Our job is implementation. I think that is going well. There are still about 18 sites I think that are still under review. There is a process that has commenced with getting a lot of community input that will result in what the disposition of those remaining 18 sites is.

With tangible things happening, there is a new hospital planned in Las Vegas. There is a new hospital planned in Orlando. I mentioned in my opening statement a transaction that is occurring in Chicago, getting rid of redundant aged stock and resulting in a new tower there.

This has to happen. It's not without controversy, and in some cases pain.

THE CHAIRMAN. Mr. Secretary, I recognize my light is on. My question is, is CARES competitive sourcing part of your plan? Then we will go to Mr. Evans.

SECRETARY NICHOLSON. Yes, it is, Mr. Chairman. I would defer to my general counsel, Tim McClain, who has a deeper knowledge than I do.

THE CHAIRMAN. Thank you.

MR. MCCLAIN. Mr. Chairman, thank you for the question. As you are aware, competitive sourcing is part of the President's management agenda, and VA is doing competitive sourcing in all non-medical areas, medical facility areas.

Currently, there is a law in Title 38 in Section 8110 that prevents VA from expending any funds to do any type of competitive sourcing for studies in medical centers or medical facilities.

Obviously, that is our greatest area of purchasing. We have supported a legislative proposal simply that would allow us to expend appropriated funds doing studies in the medical facilities.

THE CHAIRMAN. You are going to send a proposal to us?

MR. McCLAIN. Yes, sir.

THE CHAIRMAN. Thank you. Mr. Evans?

MR. EVANS. Thank you, Mr. Chairman. The Government Accountability Office has just released a rather damning report about the VA's failure to firmly implement any of the recommendations of the Advisory Committee on Post-Traumatic Stress Disorder. It seems many of the recommendations are not scheduled to be implemented until after 2007.

With this information, how can Congress have any assurance that the VA will be able to meet the needs of folks returning from Iraq and Afghanistan?

SECRETARY NICHOLSON. I am going to ask Dr. Perlin to respond, sir.

DR. PERLIN. Good morning, Congressman Evans. The PTSD Advisory Committee is an advisory committee to the Office of the Under Secretary on how we can best serve veterans. This GAO report identifies a review of progress in meeting recommendations made by that Committee.

It is not actually a report on the quality of PTSD care offered to America's veterans. In fact, they do make mention in the report that the quality of care is world class.

VA takes exception, because in fact, we would never be so presumptuous as to believe we can't improve care, but the care that is being provided is really exceptional, and we have the capacity to meet the needs of veterans returning from Operations Iraqi Freedom and Enduring Freedom.

With the support of Congress Public Law 108-170, \$5 million is directed specifically to increase support for PTSD, another \$5 million for substance abuse disorders, and another \$5 million specifically for outreach to Operation Iraqi Freedom veterans.

This 2006 budget proposes an additional \$100 million for mental health care.

We are not alone in taking exception to this report. I would like permission to enter for the record responses from the two chairs of the PTSD Advisory Committee who disagree with the findings.

The actual mechanisms may lead to some interpretation, and we will be working with the Advisory Committee, as we have, in developing a robust mental health strategic plan that meets the remaining outstanding issues.

We care for more than 200,000 patients now with PTSD. That number increases by 20,000 annually. We have the resources and the skills. We will make improvements. We are adding additional resources. We want veterans to know and we want the employees who give passionate, dedicated, and effective care to know that this care is state-of-the-art.

THE CHAIRMAN. Dr. Perlin, hearing no objection, your request shall

be entered into the record.

DR. PERLIN. Thank you.

[The material to be provided was not available at time of printing.]

THE CHAIRMAN. Mr. Evans?

MR. EVANS. I would like to ask about the enrollment fee and how that would work.

SECRETARY NICHOLSON. Yes, sir. That is a good question. The way that it would work in the categories to whom it would apply, which are the lower categories, it would be for an annual enrollment fee for their healthcare, and it would be paid in the beginning of that 12 month period, and then it would be good for that period and then renewed.

MR. EVANS. How would indigent veterans pay for that?

SECRETARY NICHOLSON. It wouldn't apply to indigent veterans, sir. It would apply only to the Category 7s and 8s who would be above the means testing in their locality. I believe administratively, it would work as it does in TRICARE for military retirees who are in the TRICARE system.

They will probably be sent a bill and they pay the bill, like they would if they had a monthly insurance premium or something. It would be an annual enrollment bill.

MR. EVANS. I would like to submit my additional questions for the record.

THE CHAIRMAN. Yes, Mr. Evans. All members may submit questions for the record to the Secretary.

[The material to be provided appears on p. 219]

THE CHAIRMAN. Mr. Bilirakis, you are now recognized. Thank you, Mr. Evans.

MR. BILIRAKIS. Thank you, Mr. Chairman.

Yes, that's working. Don't charge me with the time, Mr. Chairman.

THE CHAIRMAN. I'll restart the clock.

MR. BILIRAKIS. I want to welcome you, Mr. Secretary, and to thank you for taking on this task. It's a Herculean one, there's no question about that. I imagine your years at the Vatican were probably soft compared to this.

I want to welcome all of your staff, and of course, all of the panelists that come up after this panel.

I want to make a statement, but first, I would just say, Mr. Secretary, that we are concerned about a lot of areas, but the seamless transition issue is very significant.

I've assumed the Chairmanship for the O&I Subcommittee. I met with Mr. Strickland and other members of that O&I Subcommittee, and we are planning to travel around to see how things are really

working out.

I'm not asking a question regarding it, but I would say to you that is certainly in this day and age, with Iraq and Afghanistan particularly, it's a very important area.

Additionally, we passed the partial concurrent receipt repeal legislation. There was a Veterans' Disability Benefits Commission that is established by that law.

I understand that the Commission is moving very, very slowly. We need to hear on that. I would appreciate your letting us know, giving us an update on what is taking place there. I realize that also involves DOD as well as the Veterans' Administration. That is really one of my babies. I am very curious and very interested in knowing how that is going.

The statement that I want to make, Mr. Secretary, pertains to Cooperation on veterans' issues. I don't know what the intent was in creating this Committee.

Your role, of course, as Secretary, yes, you work for the President, whoever the President might be. I would like to think that your role is primarily a role for the veterans. I like to think that our Committee is primarily a role for the veterans.

We never get enough money to be able to satisfy all the veterans' needs. It has never happened, regardless of who was President, or regardless of who is in charge of Congress.

I used to sit over there for years and years when the other party was in charge and their Chairman used to complain about all the veterans moving into Florida every month, and how the amount of veterans' spending increased. It was just a proportion of the spending increases that took place over the years. Virtually, in every area, we saw great spending increases, 120 percent, 130 percent increases over a period of time with veterans' spending lagging behind, and only increasing like 40 to 50 percent.

We are not going to solve even a portion of these problems if we don't work together. What I am saying is we can sit up here and we can throw out the rhetoric and complain and things of that nature.

We have to get together and we have to realize yes, politics involve compromise. We have to realize that is the case. You know my credentials as far as veterans are concerned.

Either we are going to get something done that is good for the veterans or we are just going to have an awful lot of rhetoric and not really accomplish what is best for the veterans.

I'm not admonishing anybody. I've talked to the Chairman, and I've agreed to be Vice-Chairman. I said, Mr. Chairman, I'm agreeing to be Vice-Chairman because I want to be a check and balance, and he said that's why I'm asking you to serve as Vice-Chairman.

I guess my time is up. I wanted to make that statement, Mr. Chairman. I just hope, we have the TV camera here and we are going to

say certain things and it is going to play broad back home, but it's the bottom line as to what we do for the veterans, and that's what counts.

Thank you, Mr. Chairman.

[The statement of Hon. Michael Bilirakis appears on p. 63]

THE CHAIRMAN. Thank you, Mr. Bilirakis. Mr. Michael Michaud of Maine, you are now recognized.

MR. MICHAUD. Thank you very much, Mr. Chairman.

MR. Secretary, first of all, congratulations.

SECRETARY NICHOLSON. Thank you.

MR. MICHAUD. As the President described, in May of 2003, there was a growing mismatch between the demands of VA and the resources we had made. Mr. Secretary, there is a debate going on in Congress about how best we can continue to provide for high quality care of veterans who are currently serving our country. This debate is occurring while we are now at war and as the numbers continue to grow. We have some disagreement as to whom has earned the right to receive the care for veterans.

I believe caring for our veterans as Members of Congress, is part of our ongoing national security mission and therefore it should be our high priority. This budget must, as Abraham Lincoln stated, allow the VA to fulfill the mission of care for him who shall have borne the battle, and for his widow and his orphan. Veterans should not lack care. We should not abandon our long-term obligation. There are many demands on the VA; but that demand represents real veterans' real needs across America.

We have an obligation to care for those who put their lives on the line. This budget does not meet that obligation, in my opinion.

I'm also very concerned about the long-term care provisions, and their effect on local veterans' resources - the eligibility requirements for the state veterans' homes so that the vast majority of our veterans who are not in homes should suddenly be ruled ineligible. I'm not sure that's good policy.

Mr. Secretary, I'm willing to work with you on particular problems. My question is that I understand a number of veterans' integrated service networks may be experiencing budget shortfalls. First of all, have any of these veterans' integrated service networks been afforded supplements for fiscal year 2005? Is there any indication that any of these networks are dealing with shortfalls by delaying service?

And finally, the fiscal '06 budget appears to assume that VA will carry over a half a billion dollars in fiscal year '05 money. Are any of the veterans' integrated service networks able to carry that money over, or will that be a shortfall in fiscal year '06?

SECRETARY NICHOLSON. Thank you, sir. You raise some very important points.

First, let me address the fact that - this is somewhat in response, also, to Congressman Bilirakis' point of my role. I'm an advocate for veterans. When I was asked to do this job and considered it, that was one of the most appealing things to me. Because as I said, in my life, having the opportunity to serve in the Armed Services changed my life permanently to the good, and I think that has happened to millions and millions of Americans.

Americans answer to call. In a perfect world, everybody that has put on that uniform and taken that oath, I think it would be great if we could provide them with a full panoply of goods and services.

We are not in that world. We are in a more constrained world. We have to make decisions and priorities and decide who it is that needs us the most. I think that is those veterans who have been disabled as a result of their service, either physically or mentally, or contracted a chronic condition as a result of that. Those who served us and are down on their luck and down and out, and those that maybe subsequently contracted some acute condition and have a special need.

We take care of those people. Those are our priority. There are a lot of those. It's expensive.

That is the reason that we ask that we be able to continue to take care of them, and as a result, for those that are doing well and are healthy, not able to do as much as we probably would like.

Let me respond to your specific question about divisions. In my two weeks, I have not been made aware of any division that has requested additional money for any purchases or is undergoing under deferral of purchases or maintenance. I will defer to the Acting Under Secretary for help and see if he would like to add anything to that.

Dr. Perlin?

DR. PERLIN. Congressman, no VISN has submitted a request for additional funds. As you know, we have to operate to spread the resources through the year. At the end of the year, much equipment is purchased. I think you will see a pick up in purchasing of equipment at that time.

THE CHAIRMAN. I thank the gentleman for his contribution.

MR. MICHAUD. Mr. Chairman, I'd like to provide additional questions for the Secretary, for the record.

THE CHAIRMAN. Yes, indeed. If we have time, depending on the members, we could do a rapid fire second round, depending on the Secretary's time.

I now yield to Mr. Henry Brown of South Carolina. Mr. Secretary, if you need an interpreter, we can bring back Mr. Hollings. Mr. Brown is the Subcommittee Chairman on Health.

MR. BROWN. Thank you, Mr. Chairman. Thank you, Mr. Secretary. Congratulations on the appointment. I certainly look forward to working with you, as we look outside the box and meet the health care needs for our veterans.

My question is about health care resources, caring for the benefit of veterans. There is a great potential for VA and DOD and other medical entities to come together to share expensive equipment, especially services in facilities. This is seen between the Charleston Medical Center and the Medical University of South Carolina.

What progress can we expect to see in the next couple of years to facilitate direct sharing of goods and services and eliminate some of the barriers that have limited progress in such collaborations?

SECRETARY NICHOLSON. I would start off by saying that is a very positive goal. In the context of sharing facilities, we are involved in the planning and siting of a new VA hospital in Denver, which is my home town. It is contemplated that DOD will have six to eight percent of the space in that new facility.

As to the sharing of goods and services, I am going to defer to Dr. Perlin and ask him to answer that.

DR. PERLIN. Congressman Brown, we have enjoyed a close working relationship with both the Department of Defense as well as with the Medical University of South Carolina. I think we were able to help each other, as on the 75 year lease with the Medical University to transfer Dodge Street, which I understand increased access and allowed them to commence with phase one of their hospital. It has also increased revenues by \$1 million a day.

That sets the stage for additional discussions about the sharing of high tech equipment, and subspecialty services. The Department of Defense was very enthusiastic about the design phase for the community-based outpatient clinic at the Naval Weapons Station.

These are projects that we are very interested in because they improve the care of veterans and the care in the community.

MR. BROWN. Thank you very much. One of the things we were concerned with is the facilities we have in the veterans' hospitals are getting old. The Medical University is going through extensive rebuilding of facilities that are outdated.

For the benefit of all taxpayers, this would be an ideal opportunity to bring together some of those resources and establish a model similar to Colorado.

Veterans in my district, and I guess we have over 70,000, with travel between the different health facilities, some up to 150 miles away.

I think we have to find alternative ways, whether vouchers might be a solution or other revenue sharing sources.

Thank you very much.

THE CHAIRMAN. I thank the gentleman for his contribution. Ms. Stephanie Herseth of South Dakota is now recognized.

MS. HERSETH. Thank you, Mr. Chairman and Mr. Evans, for your leadership on the Committee. Thank you, Mr. Secretary. Congratulations on your appointment. We appreciate your service to the coun-

try previously and now in your tenure with the VA, in serving the veterans, and the service of your colleagues as well.

As you know, we have had an organizational change with the Subcommittee on Benefits, and I will be working closely with Mr. Boozman from Arkansas, who chairs that Subcommittee. I would like to pose a couple of questions as it relates to economic opportunities specifically in the area of education, employment and vocational rehabilitation. Then I will submit other questions as it relates in particular to the care that our outpatient clinics provide to rural veterans, which is common in South Dakota and many other districts and states represented here today on the Committee.

First, in the area of veterans' education benefits, the President's budget request would eliminate 14 full time staff positions with the VA's education service.

As you know, education claims are expected to increase due to more veterans seeking to take advantage of the Montgomery G.I. Bill, as well as the new Chapter 1607, Guard and Reserve education program enacted last year as part of the National Defense Authorization Act of 2005.

I would like to know just how this request to eliminate these full time positions would be justified.

As I'm sure you are aware, the number of veterans applying for vocational rehabilitation and employment services increased dramatically over the last decade, roughly a 75 percent increase.

Demand for this service will surely continue due to the many injuries suffered by our troops serving in Iraq and Afghanistan.

Recognizing the great importance of providing quality employment services to our transitioning disabled Servicemembers, former Secretary Principi established a task force to review the vocational rehabilitation employment program, VR&E, from top to bottom.

This VR&E task force issued a comprehensive report in May of last year. The report contained 102 recommendations to improve the VR&E program and reform it to be responsive to 20th Century needs of Service-connected disabled veterans.

The task force recommended an additional 228 full time staff positions for the VR&E program, including 27 in headquarters, 112 in regional offices, 56 in regional offices for contracting and purchasing, and eight quality assurance staff.

The President's budget request doesn't provide any resources consistent with the VA's own VR&E task force report. Rather, the President's budget simply reflects a redistribution of management and support personnel.

I would like it if you would also share your thoughts on meeting the report's recommendations in light of this shortfall of necessary resources.

[The statement of Hon. Stephanie Herseth appears on p. 65]

SECRETARY NICHOLSON. Congresswoman Herseth, those are important questions and an important area. I have spent some time, among many other things, that we have been doing the last two weeks, looking at education. I agree with you about its importance. I feel myself a product of what it can mean to you in our country.

Because they are so important, I am going to ask Admiral Cooper to answer that with more learned experience and detail than I have at this point on that. If you would, Admiral.

MR. COOPER. Yes, sir. In the education question that you asked, you will note that in 2005, we in fact had 888 people, which is the highest number we have had in education in recent years.

We took a very close look at this. We are trying to keep a balance. We had 888, which was an increase over previous years. Yes, we will drop back maybe 14 in 2006. I have to look at that.

We do not know -

MS. HERSETH. I just want to interject. I appreciate that flexibility and the fact that you keep an eye and notice that close to retirement, that we have that transition of people who can provide training for those other claims that may be coming after.

MR. COOPER. Yes, ma'am. I am watching that extremely carefully. As I say, we have that number of people. As far as the 1607, we do not know what now what the effect is. I don't think we will see much effect in 2005. Again, that is something I have to watch and make adjustments. The 1607 program just became effective last October.

We are about to sign an MOU with DOD to make sure we carry that out properly, and we are working on how to make the payments in that particular program.

We are watching that very carefully. I have very good leadership in education. I think I will have enough warning if I need to do other things, but I think right now we are proceeding properly.

The second question you had on vocational rehabilitation, we set up this Task Force because we were very concerned about not only the leadership but the execution of our vocational rehabilitation program, primarily because I think it had lost focus and was not focusing on employment. It was focusing more on training.

We have replaced the leadership pretty much across the board. We have also focused, as the study stated, on employment. As a result, we are setting up five different tracks for a veteran to gain employment, ranging from somebody coming back and getting re-employed by the previous employer through a full college education to independent living.

We have set that up at four test sites. We are continuing to run the tests for three or four more months and then we will expand that across the board to all of our regional offices.

That is the main part of the recommendations. There were 102. Of

the 102, there are probably 20 or so we will not implement. However, 34 have been implemented today, and I expect in excess of 50 percent to be implemented by the end of this year.

THE CHAIRMAN. I thank the gentlelady for her questions. To my colleagues, I have received word that we are going to have votes around 11:30. If you look at the time, if we try to restrict ourselves within the five minutes, we might be able to do this, Mr. Secretary, without your having to wait while we go vote and come back. We will see how this plays itself out.

Mr. Jeb Bradley of New Hampshire, you are now recognized.

MR. BRADLEY. Thank you very much, Mr. Chairman. I appreciate your leadership and that of Mr. Evans and Mr. Secretary, welcome to this Committee. It is a pleasure to meet you.

I would like to turn to the overall health care item in the budget, which is in the President's budget about \$30.7 billion. Depending on how you calculate it, I think you have estimated it is about a 2.5 percent increase.

My question to you, sir, is that generally medical inflation is running at a much higher rate. It could be as high as three times that, number one.

Number two, you have had staffers that have testified before Congress in the past that in order to maintain the services that veterans have come to expect, it would generally take about a 13 to 14 percent increase.

Given those numbers and the budget perspective that we see before us in this presentation, how are you going to be able to maintain those commitments?

SECRETARY NICHOLSON. That's a good question, Congressman Bradley, and one we have discussed and I discussed with my team here.

There are some major efficiencies that have been enacted in our delivery system such that it brings us down to be quite a bit below in inflation what it is in general, in the civilian component.

We can do this with this number, given our demands.

I am going to ask Dr. Perlin if he would like to add anything to that. He's the guy that has crunched these numbers the most.

DR. PERLIN. Thank you, Congressman, for the question. Your question really asks if we have the resources to do the job. In consideration of this budget with the policy proposals that it contains, we have the resources to do this job.

As the Secretary identified, we have greater efficiencies. We have efficiencies in the scale of purchases we can make. Our pharmacy program has been held to be the most efficient in the country, as represented in the Wall Street Journal and USA Today. It's ability to allow us to leverage our scale and the Federal supply schedules allows us to meet the needs with the budget.

MR. BRADLEY. Thank you very much for that answer.

My second question is that it is estimated that there will be as many as 430,000 veterans who require long term care services from the VA over the next decade, but this budget calls for a reduction in 500 beds.

Once again, how do you square that with being able to complete the mission? Thank you.

SECRETARY NICHOLSON. If you look back, Congressman, you will see that number has really drastically gone down. The number of people in beds and extended care to the model of taking care of these people now and allowing them to stay in their own habitat, their own environment, closer to their families, their spouses, if you will, their own homes.

That has been done and I think has been done effectively through the use of telemedicine, through the use of outpatient based clinical care, going out to them with both health care providers and social workers. The combination of that has brought a large reduction.

That trend is continuing. It's working. Of course, there are those for whom that doesn't work. They do need to be in a bed.

Dr. Perlin, would you like to add anything?

DR. PERLIN. Thank you. Ten years ago, we would have said the population is aging, we need more hospital beds. But medicine has moved from the hospital to the clinic. A decade ahead of us, care moves more from the clinic to the home.

Our goal is to provide care in the least restrictive environment and the most humane way possible.

The technology that the Secretary alluded to, such as the use of telemedicine, allows patients to successfully age in place and have their needs met.

This budget actually allows us to substantially increase by 79 percent the number of patients cared for in non-institutional settings.

We have increased the resources by nearly \$60 million for non-institutional care, and we have seen a growth in our care coordination, which specifically is the application of those technologies to allow those veterans, veterans with chronic illness and older veterans to successfully age in place, maintaining social, community and even spousal relationships.

MR. BTRADLEY. Thank you. Mr. Chairman, I yield back the balance of my time.

THE CHAIRMAN. Good try. Mr. Strickland of Ohio is now recognized.

MR. STRICKLAND. Thank you, Mr. Chairman. Mr. Secretary, welcome.

Mr. Secretary, in the early 1940s in World War II, this country subjected many of our veterans to mustard gas, nerve agents, and they didn't know what had been done to them. They were sworn to secrecy. They weren't followed up with afterwards. Many of them now, if they

are alive, are in their 80s.

Earlier this month, I received a letter requesting an update from VA about their contacting these World War II veterans to give them medical exams, provide them with assistance if they needed it.

In the early 1990s, the VA promised they would make every effort to contact these individuals and to see that they got the help they needed. The only thing the VA did to my understanding is to put some ads in a magazine, they put out no letters, made no phone calls, and no effort of active outreach.

As the new Secretary, I'm asking you, sir, will you do everything possible to reach out to find these individuals and to provide them with assistance that I believe this country should provide to them?

SECRETARY NICHOLSON. That's a question that is first impression for me, Mr. Strickland. I will assure you that I will take it on board and will look at it and get back to you.

I don't fully know the extent of that. I will get back with you after looking into it.

MR. STRICKLAND. I appreciate that, sir. Thank you so much. I did send you a letter earlier this month. Do you have a comment, sir?

MR. COOPER. Yes, Mr. Strickland. If I could address that for a second. We in fact are working actively with DOD right now. We have received 4,000 names. We are in the process of checking our records, and in the next two to three weeks, we will get letters out to everyone for whom we have current addresses.

We are then simultaneously contacting IRS and Social Security to get whatever other addresses we can, and for those we cannot get, we will go to a civilian group to try to find addresses.

We are in fact in the process of implementing this plan. We are giving veterans a number to call. We are also referring them to VA hospitals for medical care and so on.

MR. STRICKLAND. I thank you for your response and I thank you, Mr. Secretary, for your response as well.

Mr. Secretary, there has been discussion here of management efficiencies as a way of saving money and perhaps calling for a lesser appropriation for health care. You have indicated, I think, you are anticipating management efficiencies of two percent approximately, or \$1.8 billion. It seems like a lot of money.

If these are not achieved, and if the co-payments and the user fee are rejected by the Congress, as I hope they will be, it seems to me that the VA is going to fall far short of what is needed to provide for VA health care.

In fiscal year 2004, the VA estimated management savings of \$950 million to partially offset the cost of VA health care. That estimate was accepted at face value, was based on implementation of vigorous competitive sourcing, increasing employment productivity, shifting from patient to outpatient care, reducing travel, maintenance and

repair services and supplies.

That was for 2004. We are now in 2005. Is the VA able to document for us that those management efficiencies that were anticipated for that year were achieved? Should we not do that before we go ahead and anticipate further management efficiencies for the next fiscal year?

SECRETARY NICHOLSON. Congressman, I'm going to respond based on what my understanding is. In the last two budget cycles, we have met our expectations on efficiencies and savings, which gives us the confidence that we can meet those we are projecting for 2006.

MR. STRICKLAND. Excuse me for interrupting, sir. Time is very short. Can you or can Dr. Perlin provide us with documentation as to where and how those efficiencies were met and can we also be provided with those instances where the efficiencies were maybe not met, for example, the VA lost \$250 million, according to a GAO report on the Core FLS project.

Did you count the failures as well as the successes when you calculated whether or not the management efficiencies that were anticipated actually were achieved?

SECRETARY NICHOLSON. I'll give you a very quick answer and tell you our information at the VA is your information. We will look into that and come back to you with our answer. I don't think we can answer that on a line item basis here today.

We have had significant savings. We have had hiccups. You mentioned one of them. I feel pretty good about where we are headed and the efficiencies we are going to achieve through standardization and competitive purchasing, particularly in the pharmaceutical area, and some other efficiencies we are looking at, including in our IT area.

As to the details, we will have to get back to you.

THE CHAIRMAN. Mr. Strickland, thank you for your contribution. Please be responsive to Mr. Strickland's questions, I think it is very appropriate. He is asking for how you came up with your budget. It is really an appropriate question. Please be responsive to the member.

SECRETARY NICHOLSON. Yes.

THE CHAIRMAN. Mr. Turner of Ohio, you are now recognized.

MR. TURNER. Thank you, Mr. Chairman. Thank you, Mr. Secretary. Most of our perspectives on a national budget can be defined in part by our local experience. I want to talk to you for a moment about a local issue and ask the question as to the national policy, and I am going to return to the issue of nursing home beds.

Previously when you were answering, I understand the concepts of your shift in defining the need for long term care. I understand that with the changes that are occurring in the way services are provided, the importance of age in place and the benefits financially, but also the benefits it has to the patients themselves.

I tend to for as long as possible not shift an individual into institu-

tional care, looking to non-institutional care.

I'm also familiar with the policies that permit the VA for both access buildings, to lease them out with partner organizations, and also the provisions that allow the VA to look to the nursing home area, to look at community assets and resources as opposed to expanding veterans' VA center resources.

I'm a little concerned because last year in my community we have a nursing home facility that had been renovated, and is a quality facility by everyone's standards. It was providing quality services. An unexpected announcement was sent to all the residents that it was going to be closed and they were going to be returned home or sent out to a community facility as part of the policy of looking to community assets.

Obviously, my understanding was that the community use of resources was to prevent expansion but not to be used for closing a facility.

Mr. Secretary, your predecessor in October came to our community and reversed that decision and allowed the nursing facility to remain open and the patients could stay there.

In looking to the large population that you have that is coming and still looking at the alternatives of care that you are going to provide so that you don't have the same stream percentage that would end up in institutional care, it still seems to me that it is an important role for the VA to play in having nursing home facilities.

The reports I received were not only just quality of care but also the comradery, the spirit that occurs within a veterans' nursing facility that contributes to the overall success of long term care for the patients.

In looking at the policy and the issue of eliminating your average daily census issues and reductions in beds, I want to make certain that you are not looking to a policy of actually the VA center receiving in its nursing care facilities to get out of the business and to quit providing that service.

SECRETARY NICHOLSON. It is an important question, Congressman. Thank you. I can assure you that the VA is not looking at getting out of that business. There are those that really need it and are counting on it and need to be there.

There are categorical priorities of those who need it the most, and that is who we need to prioritize so we can serve.

I am going to ask Dr. Perlin if he would like to detail that a little further as to those people who need that care and that we will be there for them.

DR. PERLIN. Mr. Congressman, as the Secretary has said, we are not looking to get out of the nursing home business. However, our care will be delivered first and foremost to those most highly service-connected veterans in Priority Groups one through three, and to those

veterans who really have difficulty in having their needs met elsewhere, such as those with special needs like ventilator dependence. We will be there for those veterans as well.

Those veterans who are coming out of the hospital and need acute rehabilitation to get back to normal living, we will be there for those veterans.

Those veterans who require hospice care, we will be there for those veterans. Those veterans whose families need respite from caring for those veterans 24 hours a day, we will be there for those veterans as well.

The commitments, as I've detailed, will be there for those veterans whose needs can't be met appropriately in the community environment with new technologies.

MR. TURNER. Since I have just a moment, since you gave that list, again, my question concerns your actually being the direct provider of the nursing home services versus just looking at scattering the services out in the community.

Will you have a nursing home facility that is of high quality and providing quality services?

DR. PERLIN. Yes, we will continue to have the nursing homes at our VA facilities, absolutely.

THE CHAIRMAN. The gentleman's time has expired. Ms. Berkley to inquire.

MS. BERKLEY. Thank you very much, Mr. Chairman, and thank you, Mr. Evans, for your leadership. Welcome, Secretary Nicholson. I am looking forward to working with you. I had a wonderful relationship with your predecessor. He was responsive and accessible.

Please take this as an invitation to visit us in Nevada. On behalf of myself and the veterans that I represent, I want to thank you for including in the 2006 budget funding for a full service VA medical center that we desperately need. The medical center will have a long term care facility, a hospital, and an outpatient clinic, none of which we have now. I am very excited about that.

However, in the 2006 budget, there is \$199 million that has been requested, and that is \$27 million short of the projections on what it will cost in order to build this facility. I understand the \$27 million will be requested in the 2007 budget, and construction will be completed in 2009. Can you confirm this? And when do you expect us to break ground? And when do you expect these facilities to be completed?

SECRETARY NICHOLSON. Thank you, Congresswoman. What I can't tell you - and if someone else at the table can, I would like them to do so - is when we anticipate breaking ground.

DR. PERLIN. I will have to get back to you with the exact information.

MS. BERKLEY. I have been a buffer to protect my constituents. I

think it is important to get this information.

Let me just say very, very quickly, because I know the time is short, what my veterans are saying. I have heard an awful lot from my veterans about the President's State of the Union address.

There is particular concern about the \$250 user fee and the co-pay. Most of my veterans are seniors on fixed incomes, and this is a lot of money. I have never heard from a veteran from anywhere - Vietnam, Korea - that hasn't said the same thing about when they enlisted, what they were promised from the person that enlisted them.

There is no contradiction here that they were promised health care benefits for life. Again, I've never heard anyone say that is not what was said. They had an expectation of this. I just wanted to put that in your mind, that this is not going over particularly well.

The President's budget provides \$762 million less than needed to maintain current services for veterans' health care. This turns into a loss of almost 3,000 nurses nationwide. I have a huge and critical nursing shortage in southern Nevada. The VA has done an extremely good job in recruiting and retaining our nurses, but if there is a cut, we are going to lose them and they are going to go back to the numbers that we used to have, and instead of having a vacancy rate of 2.5 percent, which is quite good, that is going to go up dramatically.

The budget also has a cut of \$350 million for veterans' nursing homes. I can't remember who brought that up in their line of questioning. I have no nursing facilities for veterans, as you know. They are going to be built, and hopefully, they are going to be done by 2009.

I do have a state home, but even the executive director of the Nevada Office of Veterans' Services said the President's budget limits nursing home grants to those severely injured in the line of duty.

I don't have any other facilities to send my veterans to. We have a critical nursing home shortage in southern Nevada. We can't move our veterans anywhere else. I have tremendous concerns about that.

I hope that you will take a good look at the proposed budget and help the President see that some of these cuts are inconsequential in the scheme of things, and I know you are dealing with a huge budget and have extraordinary needs and limited resources. These cuts are going to do a tremendous disservice to our veterans and do damage.

On mental health issues, a large number of my veterans, particularly from the Vietnam era, need to be provided mental health counseling, and particularly those coming back from Iraq. I've seen it happen with my Vietnam era veterans that have suffered tremendously because of the lack of mental health care. It would be inexcusable not to provide these services and adequate funding needed to do that.

Thank you very much.

SECRETARY NICHOLSON. Thank you.

THE CHAIRMAN. Ms. Berkley, we gave you great latitude, because Mr. Bilirakis and I have talked several times before about the concerns that you have in Nevada; this influx of population is something that no one else is experiencing around the country at the level that you are. We want to be very responsive.

Mr. Filner, you are now recognized.

MR. FILNER. Thank you, Mr. Chairman. Welcome, Mr. Secretary. Before I start, I want to make sure we have a recording of Dr. Perlin's advocacy of bulk purchases and how great that was for our nation. You should tell the President that so we could get a Medicare bill that says the exact same thing, which we are prohibited to do by law right now. I hope you will go to the President immediately!

Mr. Secretary, welcome. You said you were an advocate for veterans. In answer to the same question later on, you said basically we are "going with the VA we have rather than the one we want," paraphrasing the Secretary of Defense.

I see those two statements to be in contradiction with each other. I don't think an advocate would give us a budget that basically says that it is the veterans who are going to have to pay for the deficit that is created by the same administration that is proposing the budget.

It is the veterans who are going to have to deal with that. Mr. Bradley brought up the point, and I am going to drive it home clearly. It is the VA that said a year or so ago that it may take a 12 to 14 percent annual increase just to keep up with the services that you have, and even more, I think, is needed with not only the people coming back but what we have learned about Hepatitis C, PTSD, et cetera.

Our needs continue to increase, and yet you come here with a budget - if you don't get your legislative proposals for the enrollment fee and the co-payments - that proposes less than one-half of 1 percent increase in the health budget for the veterans of this nation.

That is not advocacy! We have an administration that says support our troops, support our troops, and when they come home, they are going to find a VA that is not adequate to the needs they have.

The President presents to us a Social Security proposal that is estimated to be trillions of dollars, gives tax cuts with a couple of trillion to the wealthy, and yet when it comes to the veterans, says "I'm sorry, we have to save here," I say that if the choice is giving more money to people who have it rather than what was promised to veterans, I am going to choose the veterans every time.

You also said "your information is our information." What did you ask OMB for in your budget request?

SECRETARY NICHOLSON. Congressman, I was not involved in -

MR. FILNER. Come on, Mr. Secretary. Tell me what the previous Secretary asked for.

SECRETARY NICHOLSON. I don't know.

MR. FILNER. You don't know what your own department asked from

OMB for our veterans? You say you are an advocate. How do you not know that?

SECRETARY NICHOLSON. This budget was a year-long -

MR. FILNER. Don't play games, Mr. Secretary. You can just ask somebody. Ask any one of these people.

SECRETARY NICHOLSON. Mr. Cooper, do you know what was asked for from OMB?

MR. COOPER. If I could, Congressman -

MR. FILNER. Admiral Cooper, do you know?

THE CHAIRMAN. Mr. Filner, I think it would be productive for us not to quibble with the Secretary.

MR. FILNER. I asked a question after he said your information is our information. He doesn't know what the request from his own department was to the Budget Office. That is inexcusable.

SECRETARY NICHOLSON. When I was answering Mr. Strickland's question, things that are developed, policies, and accounting records and things for the public domain are certainly yours and would be made available to you on your request.

MR. FILNER. Are you familiar, in your two weeks as Secretary, with the Independent Budget?

SECRETARY NICHOLSON. Yes, sir.

MR. FILNER. I would read it carefully. Most of us take this as a Bible. It is put together by people who understand the system. They are not asking for the moon. They are not asking just for the asking. It is a professional and very conservative look at the VA, what it takes to save the veterans.

They have asked, if you take out your legislative proposals, for \$3.4 billion more than your budget. \$3.4 billion. That is the highest figure since I've been on the Committee of the difference between an administration budget and an Independent Budget.

If you don't get your legislative proposals -- the enrollment fee, which I think is disgraceful. You have to pay, after you have been a veteran, to use our system? Come on. If you are not going to get that, I don't understand how you are going to meet the needs of our veterans with that \$3.4 billion deficit, just from a very conservative look at what the VA has to do. I don't know how you are going to do it. I think you better advocate for more money. I certainly would advocate to get you more money. If you do, I hope you will use it wisely.

Certainly, this Congressman and most of the people on this side are not going to vote for a budget that is not worthy of our veterans.

THE CHAIRMAN. I thank the gentleman for his contribution. I look to Mr. Boozman of Arkansas, the Subcommittee Chairman on Economic Opportunity.

MR. BOOZMAN. Thank you. I don't have a question. I just have a comment. Again, I welcome you here and look forward to working with you and your staff as we have in the past.

As Chairman of the Economic Opportunity Subcommittee, again, on the seamless transition, it is very important. We are going to make sure that the VA, VETS, National Guard, DOD, all work together as these guys come home and again assure that we truly do have a seamless transition.

Again, thank you for being here and I look forward to working with you.

SECRETARY NICHOLSON. Thank you, sir.

THE CHAIRMAN. Ms. Corrine Brown of Florida.

MS. BROWN. Thank you, Mr. Chairman and Mr. Secretary.

The first President of the United States, George Washington, said the rate at which our young people are likely to serve in any war, no matter how justifiable, should be directly proportionate as to how they perceive the veterans of earlier wars are treated and appreciated by their country.

As far as I am concerned, this budget should be dead on arrival. The President and the administration proposed to the Congress and we decide priorities. You can say something about a country, about priorities, by the budget, what we hold as important.

We practice reverse Robin Hood, robbing from the poor and working people to give tax breaks. These veterans have paid their dues.

I live in Florida. Most of my case work are veterans. They can't get into the system. They have long waiting lists. There is some problem. One-third of the veterans are in the streets, one-third of the homeless people on the streets are veterans because they are not getting the proper health care or they have fallen through the system.

How do we propose - most of us in Congress think nothing of a co-payment of \$10 to \$15, but our veterans cannot afford it. We are trying to fund a department to increase fees. That is unacceptable.

I have been on conferences with the House and the Senate. When we get in the closed door, we can't afford it. That is unacceptable. How are these veterans going to afford these additional fees is what I want to know.

SECRETARY NICHOLSON. Thank you, Congresswoman, particularly for the obvious concern you have for veterans. Let me respond in a couple of ways.

One is to point out to you that this Administration brought about with the help of the Congress almost a 50 percent increase in health care benefits and pension and compensation benefits since it has been here.

This year does represent a pause, if you will, in that incline that you have seen.

MS. BROWN. Mr. Secretary, did you know that the increase had gone up to 130 percent, the increase in needs?

SECRETARY NICHOLSON. We are serving a million more veterans than we were in fiscal 2001.

MS. BROWN. The veterans, the ones I'm talking about are the ones that are older, they don't have the income. They have a lot of needs. They are very frustrated. When I talk to them, they are almost in tears because they feel in their prime time, they gave their best to this country.

The question is what are we going to give back to them. Maybe I'm the only one in this body that has these kinds of veterans. They move to Florida. They have high expectations. We are not meeting their needs. It's a constant fight.

We want to close some of the sites. It is just one thing after another. The veterans are not getting what they need from the system. We have the money. It's just the matter of priorities. They are not priorities with this Administration. I hope to God it will be a priority with this Congress.

Every year, we have this fight. Let me tell you, Secretary Jesse Brown. I dearly loved that man. He fought the administration for veterans. He didn't care who the President was. He was an advocate for the veterans. That's why I'm on this Committee and have been on this Committee for 13 years. I care about them. I'm going to fight for them.

As far as I'm concerned, this budget is dead on arrival. I yield back the balance of my time.

[The statement of Hon. Corrine Brown appears on p. 67]

THE CHAIRMAN. I thank the gentlewoman. I will yield one minute for a rapid fire for anybody who may have follow-up. Mr. Michaud, you are now recognized for one minute.

MR. MICHAUD. Thank you, Mr. Chairman. Togus Hospital in Maine actually has reported a shortfall. They have been told that the delivery of the MRI machine has been postponed, which actually could save a lot of money. I'm sure if that happened at the Togus Hospital in Maine, it is happening elsewhere.

I would just ask that VA please look at that. I know that is a big problem.

SECRETARY NICHOLSON. Thank you. We will look into that.

MS. BROWN. Mr. Chairman?

THE CHAIRMAN. Ms. Brown.

MS. BROWN. I just want to make sure that the questions that I have

THE CHAIRMAN. Hold it just a second. Mr. Michaud, do you yield back?

MR. MICHAUD. I yield back.

THE CHAIRMAN. Will the gentlewoman yield for a moment?

MS. BROWN. Yes.

THE CHAIRMAN. Mr. Bilirakis?

MR. BILIRAKIS. The Veterans Administration has now and has al-

ways had input into the formation of the President's budget, yes or no?

SECRETARY NICHOLSON. I can tell you it has in this budget, yes, sir.

MR. BILIRAKIS. Thank you, Mr. Chairman.

MS. BROWN. I move that my questions will be made a part of the record. I want to know that my questions are going to be answered.

THE CHAIRMAN. We will ask the Secretary, just as we did with Mr. Strickland, that for any questions submitted by any member of this Committee, the answers shall be responsive. If they are not, you may resubmit.

SECRETARY NICHOLSON. Indeed. Let me say I welcome the oversight responsibilities that you have for this agency. It is a very big agency, there are 235,000 people throughout the country. From what I've seen so far, they are fantastic.

Whenever someone is performing an oversight or an audit, I would welcome to hear about that. We want to do the best job we can.

MS. BROWN. Thank you.

THE CHAIRMAN. Mr. Filner?

MR. FILNER. Thank you, Mr. Chairman.

Mr. Secretary, you are in a difficult position as you are representing the administration as Secretary in presenting the administration's budget. You also understand that we have looked at your predecessors as advocates for veterans.

I guess I just wish that in your testimony, you were more honest; you are not going to make the efficiencies, and you know it. You are not going to get the legislative proposals, and you know it. You going to have less money than you know you need.

Just state that. What would you like to do? You are the professionals. Get across what you need to do the job for the people who have given us this nation. You know these things in this budget are not going to happen. It's a charade.

Let's get to realities.

SECRETARY NICHOLSON. Could I respond, Mr. Chairman?

MR. FILNER. I would like to submit my questions, too, since everybody else is.

SECRETARY NICHOLSON. I would like, if I could, just to respond in one way to your point, which I appreciate. In the interest of just making sure that people understand what we are talking about in this realm of the enrollment fee and a co-payment, we have prepared a little chart that I would like to submit for the record, if I could, Mr. Chairman.

THE CHAIRMAN. It will be entered without objection.

[The provided material appears on p. 406]

SECRETARY NICHOLSON. We will distribute it to the members. It is showing the medical care regime for a person who served 20 years in

the Service. The example they have used would be a sergeant E-7 with 20 years of service that is receiving TRICARE under the DOD program, which I think you will find is almost universally acclaimed by the people that are using it.

Those are the people that when they took the oath and the recruiter told them if you serve a career in this, you will be given health care for life. Those are the people to whom that was told, I think, and to whom it is indeed owed. They now have, because of you, this TRICARE system, which everybody I've talked to really likes it.

If you look at this, you will see this is somebody who served 20 years who is paying an enrollment fee for services and certain co-pays for services.

The proposal that we have in this budget, Mr. Filner and members, is for those people that in a means test of the local income levels are able to pay this. It is not for the poor veteran.

MR. FILNER. Do you know what that number is?

SECRETARY NICHOLSON. It varies.

MR. FILNER. It is around \$25,000.

SECRETARY NICHOLSON. I think in San Francisco, it is about \$71,000.

MR. FILNER. People earning as little as \$25,000 could be in this category. I would not call them all that able to contribute to the medical care they were promised.

THE CHAIRMAN. I appreciate the gentleman's slow fire.

MR. FILNER. Mr. Chairman, could I also introduce into the record the budget of 2006, the Independent Budget and the differences? I would like to introduce that into the record, also.

THE CHAIRMAN. Without objection.

[The provided material appears on p. 407 and p. 408]

MS. BROWN. Mr. Chairman, one other point, please.

THE CHAIRMAN. Yes, ma'am.

MS. BROWN. The Secretary just mentioned this schedule with TRICARE, which I think is a very good program, for people who have served 20 years or more.

We need to keep in mind that some people go into the Service that don't even live 20 years, particularly in time of war.

The question is we should not pit one veteran against another. What we need to do, in this country, we don't have proper health care. That's a problem. Those people who have contributed to this country and when they need help and assistance, the question is whether or not they are going to be a priority and whether or not we are going to be there for them. That's the question. I don't know the answer.

Thank you.

THE CHAIRMAN. I thank Ms. Brown for her contribution.

Mr. Secretary, I want to thank you for coming. I want to thank you

for bringing your staff on the formulation of the President's budget. I also thank you for telling your story and where you came from, a town of 99.

I grew up in a town of approximately 200. I took my oath as a cadet at the Citadel, but I remember my commissioning oath at Fort Bragg, given to me by Lieutenant Colonel O'Johnson.

Why do members of the military remember their oath? They remember it vividly because they said they will give their life to defend the Constitution. It is an oath which they embrace and it is implanted in their minds. We are then inculcated with what are called values. We refer to them as military values. I read them with regard to all the branches of our Services.

It is the bond which we all share. It is the dimension by which we see the world. It is our common understanding and it is our bond.

With regard to the prioritizations of care, Congress, when we did the eligibility reform, set out the priorities of care. As we set forth those priorities in categories one through six, it is the responsibility, I believe, of the nation to care for the disabled, the injured, the veterans with special needs and the indigents. Those are the priorities the nation held for a very, very long time.

When we did the eligibility reform, we had hoped and made assumptions that as we would open it up to the non-Service-connected disabled veterans and non-compensatory veterans, that we would bring efficiencies and economies of scale.

We received testimony from many that it would be budget neutral and in fact, it would be an enhancer, a revenue stream.

The reality is that it is not what happened. We are now at war and we have some challenges. We have over 10,000 wounded. We have a VA that has perhaps a generation skip with regard to handling some of these catastrophic injuries the actual duty force is about to hand off to you, Mr. Secretary.

The generation skip means the VA knew how to handle a lot of these catastrophic injuries from World War II, Korea, and Vietnam. They cared for the aged population, and now we have something pretty strong coming our way. We will also have as many as 100,000 veterans with post-traumatic stress disorder.

When we refer to caring for the veteran, it is not only the physical disabilities but also the mental.

We also in the generosity of this Congress said to those soldiers, sailors and Marines, who are in these operations in Afghanistan and Iraq, that when you come back home, we are going to care for you for two years. We have also opened up more enrollment into VA health care.

Beginning to understand the impact of that is something we have to do.

How Congress did that I believe is the fulfillment of our values, the

reason we set out these priorities of care.

I appreciate your highlighting with regard to the TRICARE system. Again, with that system, there was no push back from anyone with regard to the co-pays and deductibles. As a matter of fact, I think Mr. Bilirakis is correct. Maybe if we had been better listeners to Dave Gorman of the Disabled American Veterans who raised the concerns echoed by OMB and CBO, perhaps if we had created that system with those deductibles like that, maybe we wouldn't be where we are today.

When you create a system and then you try to add something to it later, you get an echo. You get a reaction. That is what we have right now. We have to work through this. This will be very challenging for the members of this Committee.

I also want you to know that with regard to the disabled and the injured and special needs veterans, we will work with you with regard to how we focus on our core constituency of the VA. We will make sure there is a centric in our focus. We want to make sure that just because their life has changed, that we ensure they have the opportunity to live, and that means beyond governmental assistance.

Just because you send them a check and they find their life in a bottle, that is not a quality of life.

We reorganized on this Committee to work with the administration on these focuses at this time of war. We took the Benefits Committee and we cut it into two subcommittees, and working with the minority to in fact carry forward on that obligation.

I will let you know that we are reorganizing our appropriations process here in Congress. When I went before the Steering Committee with regard to this Chairmanship, I gave a recommendation to the Steering Committee that they reorganize the appropriations process, that they take the military personnel and MILCON and marry that with the VA.

The reason I asked that the personnel of the military be with the VA in the appropriations process is the TRICARE program that you just mentioned.

As we can talk about these efforts with regard to seamless transition, sharing initiatives between DOD and VA, and having one decision maker, one Subcommittee in appropriations, to work with us in these endeavors, I am most hopeful that never again will we have these scenarios whereby the Army buys one digital x-ray machine, the VA buys one, it is right across the street, and yet the two systems are incompatible and can't talk to each other.

Hopefully we are going to end that kind of stuff and we are going to work together, and that is the reason we did that appropriations process.

I wanted to highlight the changes we had made here in Congress. Mr. Secretary, we thank you. We thank your staff. We look forward

to working with you during these very difficult times.

The Committee will also be submitting questions for the record. Again, please be responsive to any written questions. Thank you, Mr. Secretary.

SECRETARY NICHOLSON. We will be glad to. Thank you, Mr. Chairman.

THE CHAIRMAN. Our second panel consists of representatives of the Independent Budget. We have Mr. Richard Jones from AMVETS. Joseph A. Violante of the Disabled American Veterans. Richard B. Fuller of Paralyzed Veterans of America. Mr. Dennis M. Cullinan of Veterans of Foreign Wars.

These gentlemen are the national legislative directors for their respective organizations. Gentlemen, if you would please proceed to the witness table.

For my colleagues, the 11:30 vote got pushed back to 12:00. We will just wait to hear the bells.

Gentlemen, we are prepared to take your testimony. We will proceed in any order which you gentlemen prefer.

MR. JONES. Mr. Chairman and Ranking Member, Mr. Evans, members of the Committee, my name is Rick Jones, AMVETS Legislative Director and Chairman of The Independent Budget steering -

THE CHAIRMAN. Would the gentleman suspend? Will the members please come to order. You may proceed.

MR. JONES. Thank you, sir. My name is Rick Jones, Chairman of The Independent Budget Steering Committee.

With your consent, sir, we would like to proceed having PVA give the health portion, Disabled American Veterans presenting the benefits area, the Veterans of Foreign Wars presenting the CARES construction portion, and have AMVETS follow up with the burial option.

THE CHAIRMAN. With no objection, your written testimony will be submitted for the record.

STATEMENTS OF RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; DENNIS M. CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; AND RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF RICHARD B. FULLER

MR. FULLER. Thank you, Mr. Chairman. I'm Richard Fuller, national legislative director for Paralyzed Veterans of America.

In the 19 years since The Independent Budget was published, PVA has always coordinated the medical care section. I will confine my

remarks to that issue.

The Administration's 2006 budget request provides very little if any new appropriated dollars for the VA health care system. It relies on overly optimistic third party collections, as usual, accounting gimmicks, and totally unrealistic management efficiencies to derive its budget figures.

The Independent Budget gives a clear assessment of the coming needs and rising costs of health care, projects VA will need a \$3.4 billion increase in 2006. At 12 percent, this increase is actually below the 13 or 14 percent the previous Under Secretary for Health testified before this Committee that he would need.

In the interest of time, I would just like to make three points. For the past two years, the members of this Committee and its counterpart in the other body, likewise, the appropriation committees, have realized that a \$250 user fee and a \$15 prescription co-pay are unduly onerous to veteran patients, and they were rejected.

We urge the Committee to reject these proposals once more. Two million veterans would be affected by these increases.

Mr. Chairman, I would just like to briefly raise one point about a misconception that has been repeated several times during this hearing, that these increases in fees would only apply to category 7s and 8s. They also apply to catastrophically disabled veterans in category 4, who are in category 4 because of their special needs. This would increase the burden on these veterans who are in great need of specialized health care, paraplegics and quadriplegics seeking care for specialized services at VA.

Secondly, the effect of the proposed drastic reductions in funding would be catastrophic. Finally it is true we have seen increases in past years, but we have a fluctuation now of funding up and down, up and down, which makes it very difficult for VA to manage itself.

For that reason, we continue to ask the Congress to provide a guaranteed funding plan for the VA health care system.

[The statement of Richard B. Fuller appears on p. 85]

THE CHAIRMAN. Thank you, Mr. Fuller.
Mr. Violante?

STATEMENT OF JOSEPH A. VIOLANTE

MR. VIOLANTE. Mr. Chairman and members of the Committee, good afternoon. I'm Joe Violante with Disabled American Veterans.

As with our primary responsibility in the Independent Budget, I will address mainly the recommendations for the benefits programs.

This year, the President's budget recommends only one legislative change for veterans' benefits, that is a cost of living adjustment for compensation. We support that recommendation. We include a num-

ber of other recommendations in the Independent Budget. I won't attempt to cover those at this time.

I hope the Committee will refer to the IB for specifics and for reasons for these recommendations.

For our benefits program, we mostly need some fine tuning to make them better serve their purposes. Persistent problems with the delivery of benefits diminishes their effectiveness.

The optimum efficiency obtainable in the administration of programs cannot overcome inadequate resources. Year after year, the President's budget requests inadequate resources, but supposedly contain the right solution to fix the problem nonetheless.

Year after year, the problem remains unfixed. The solutions are flawed because they are built around inadequate resources. No one disputes that the VA can obtain and should continue to pursue new efficiencies, but highly optimistic and vaguely conceived new efficiencies cannot justify cutting the workforce and investing too little in tools to do the job when VA is already in the hole.

Past reductions in the workforce are the foundation of the problems. If the VA continues to curtail its resource requests to extraneously impose budget targets rather than requesting resources called for by a realistic assessment of its production capacity in relation to its workload, its service to veterans simply cannot improve to acceptable levels.

In the Independent Budget, we endeavor to provide a more honest assessment of VA resource needs. I will again refer you to my written statement and the IB to cover the specifics.

I simply say here that we recommend more employees for the Veterans' Benefits Administration than in the President's budget. We recommend funding for information technology initiatives, to which the President's budget appears to include no funding.

The President's budget claims that its priority goal is to improve the timeliness and accuracy of claims processing. The inadequacy of the resources it requests contradicts that claim, however.

In preparing your views and estimates for the Budget Committee, we therefore urge this Committee to consider our recommendations in light of these inescapable facts.

That concludes my statement, Mr. Chairman. I'll be happy to answer any questions a member of this Committee may have.

[The statement of Joseph A. Violante appears on p. 91]

THE CHAIRMAN. Thank you.
Mr. Cullinan?

STATEMENT OF DENNIS M. CULLINAN

MR. CULLINAN. Thank you, Mr. Chairman and members of the

Committee. I am Dennis Cullinan. I'm the legislative director for the Veterans of Foreign Wars of the U.S., and on behalf of the 2.4 million men and women of the VFW and our auxiliaries, I express our deep appreciation for being included in today's important VA budget hearing.

The VFW is responsible for the construction portion of the IB, so I will limit today's testimony to two main areas, CARES and long term care.

In light of the administration's totally inadequate budget request for VA, we are very concerned that Congress may not adequately fund all CARES' proposed changes and projects. This will greatly worsen the obstacles now impeding veterans' timely access to quality health care.

It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated in a separate account for construction of new facilities and renovations of existing hospitals.

Supporting this view is the fact that the Administration's budget would devote the total funding for major or minor construction of \$699.8 million to CARES, leaving nothing for non-CARES' projects.

Mr. Chairman, it defies credibility and good reason that the VA will or should suspend all non-CARES' related construction projects to include essential non-recurring maintenance, seismic corrections and other safety issues and so forth. It is for this reason that CARES be funded separately to provide sufficient funding and to avoid the temptation to engage in this kind of budgetary slight of hand.

We recommend that Congress appropriate, not including funding specific to CARES, \$562 million to major construction for fiscal year 2006. We also recommend that Congress appropriate \$716 million to the minor construction account.

With respect to long term care, we are equally dismayed. The budget proposal slashes \$350 million from veterans' nursing homes by serving 20,000 fewer residents and completely eliminating \$104 million in state grants.

This would have devastating consequences for veterans in need of long term care and the system that is to serve them into the future.

In total, the Administration plans to save \$606 million by restricting eligibility to nursing home care.

VA and the nation has an obligation to provide for a full continuum of health care to those who served this country. Long term care is an essential part of this. This budget advocates that responsibility.

We look to you, Mr. Chairman and the other members of this Committee to come to the aid of this nation's veterans in need and reject this proposal.

Thank you, Mr. Chairman. That concludes my testimony.

[The statement of Dennis M. Cullinan appears on p. 99]

THE CHAIRMAN. Thank you.
Mr. Jones?

STATEMENT OF RICHARD JONES

MR. JONES. The members of the Independent Budget recommend Congress provide \$204 million in fiscal year 2006 for the operational requirements of the National Cemetery Administration and the National Shrine initiative, and a backlog of repairs.

In total, our funding recommendation for NCA represents a \$40 million increase over the Administration's request for next year, an increase almost entirely aimed at improving the NCA shrine initiative.

As you know, pursuant to past legislation, VA awarded a contract to Logistic Management Institute to conduct an assessment of veterans' burial needs. One of those reports entitled National Shrine Commitment, dealt with capital improvements needed at existing veterans' cemeteries.

It identified 928 restoration or repair projects estimated to cost \$280 million. The Independent Budget veterans' service organizations recommend funding be accelerated to correct current issues. We all know delayed maintenance results in an exponential increase in the costs of repairs.

We also recommend in the document certain burial benefits be increased and enhanced, rather than be eroded as they have in value over the years.

In the series of benefits recommended, I would like to highlight one matter. With the heightened interest in increasing the Service member's death gratuity from \$12,000 to \$100,000 or more, the Independent Budget service organizations ask you to recognize that deaths also result from the wounds incurred in service long after the last shot is fired.

We therefore recommend a modest increase in the Service connected benefits to \$4,100 from the current level of \$2,000. That is one-third of the current rate for those killed in service, in combat. It is much less in the sights of what you are currently focusing on.

This request, of course, would restore the allowance to its original proportion of benefits and burial expense and tell all veterans that their sacrifice is given in appreciation as it so well deserves.

We thank you, sir, for allowing each of us three minutes to present our portions of the Independent Budget.

[The statement of Richard Jones appears on p. 104]

THE CHAIRMAN. Thank you very much. I want to thank the gentlemen for coming to Charleston. I think it was a very productive day. Any time we can get out of this town and sit down and have some

frank discussions, I think it's a good thing.

The first thing I would ask of each of you, tell me where you were when you took your oath, either of enlisting or commissioning.

MR. FULLER. Mr. Chairman, I was at Fort Hollin outside of Baltimore. I don't think it exists anymore, and I hope it doesn't.

THE CHAIRMAN. Mr. Violante?

MR. VIOLANTE. I was attending University of Dayton and decided it was time to drop out of school and enlist, so I enlisted in Ohio and took my oath in Cincinnati, Ohio.

MR. CULLINAN. Mr. Chairman, I was in the Federal Building in Buffalo, New York on August 23rd, and it was warm for a change.

MR. JONES. Fort Dix, New Jersey, 1970, a few days before Thanksgiving.

THE CHAIRMAN. Thank you, gentlemen.

One of the things that I learned is you can take a lot of experts and you can take a lot of economists, and they build their modeling to determine the financing. In the end, it still is very difficult, because we are dealing with a ghost population. People that ebb and flow and utilize many different systems.

It's challenging to come up with a good number. The VA uses a private sector actuarial firm to help develop their estimates of the funds needed to provide care to all veterans.

I'd like to know who develops the estimates that are used in the Independent Budget and what are the assumptions that are used to ensure that these projections accurately reflect the health care needs of the enrollees.

MR. FULLER. Mr. Chairman, we use the same formula that VA uses in preparing its budget for its submission to OMB. You basically break down personnel costs, regular inflationary increases and medical inflation increases, plus projections of increases in demand that will be placed on the system.

I think you heard a lot about the shrinkage in the number of nursing home beds in the system today. Likewise, the same is true as far as mental health beds are concerned. We add initiatives into The Independent Budget in order to ramp those programs back up, as the Congress has mandated by statute.

Our budget is accumulated every single year based upon what we factor the needs are. In past years, we have had communications with VA officials who called our numbers basically on track.

THE CHAIRMAN. Gentlemen, I think it would be helpful to me, I appreciate your oral testimony, if you would place in writing the science behind how you come up with your budget estimates. It would be very helpful. People like to use numbers and they throw them around. If I know the methodology, how you came up with those numbers, I think it would be very important. Some people place a lot of credibility with them, and I need to know.

MR. FULLER. We will be happy to provide that, Mr. Chairman.

THE CHAIRMAN. Thank you very much. Mr. Filner?

MR. FILNER. Thank you for being here. Mr. Chairman, I take it we are having a meeting tomorrow to submit our views and estimates to the Budget Committee? Is that correct?

THE CHAIRMAN. Yes, we are, 10:00 a.m. We are to hold a business meeting tomorrow. That is what we are going to do, we are going to sit down and talk about it; the challenge we all have is that this Committee's views and estimates are to be reported to the Budget Committee on the 23rd.

MR. FILNER. We are not voting on that tomorrow?

THE CHAIRMAN. We are holding the business meeting at 10:00 tomorrow morning, Mr. Filner.

MR. FILNER. Okay. The Independent Budget is one that many of us, certainly on this side, take very seriously.

As I said earlier, the President submitted a Social Security proposal with a couple of trillion dollars worth of borrowing.

If they can propose borrowing for Social Security, if there is borrowing to fund a tax cut, borrowing to fund a war, and yet the veterans have to stay within this fixed budget. We have the money. It has been spent everywhere else. We are putting our VA budget under different rules, Mr. Chairman, and I think that is wrong.

I heard mentioned "core veterans." Is there any definition of that? Is there a definition? Does anybody know?

MR. JONES. Title 38, there are no words in the code that say this is a core group to be served. The Veterans Administration was opened to all veterans according to the appropriations available and gave the Secretary some authority to make decisions regarding the resources he had at the time.

MR. FILNER. I agree with that. I think we can serve all veterans with high quality health care.

Thank you, Mr. Chairman.

THE CHAIRMAN. I thank the gentleman for his contribution. Mr. Bilirakis?

MR. BILIRAKIS. I find myself agreeing at least in part with Mr. Filner in that I do also believe -

[Laughter.]

MR. BILIRAKIS. Come on, we haven't disagreed that much, for crying out loud. You just handle it differently than I do.

I believe our veterans deserve complete coverage. I really do. That may be one of the reasons why I am vice-chair of the Veterans Committee.

We could probably approach something like that if we would all work together, but we don't. You pit us one against the other with your Independent Budget.

I remember in the days when the other party was in charge. I don't

remember an Independent Budget. I don't remember going through an Independent Budget business or anything of that nature. I don't remember that.

We were dealing with the President's budget, whoever the President happened to be, and trying to work with that, and in the eyes of some people, it was good, and in the eyes of other people, it is not so good. I was generally in the category of people thinking it was not so good.

Bob, you remember that. We have worked well together over the years.

As far as the President's budget is concerned, it is a negotiating point. It's a draft. I suspect your Independent Budget is intended to be a negotiating point or a draft.

I would hope that you would expect us to come up with something so that we are not pitted against each other. That's ridiculous for us to be pitted against one another. I'm not saying you intend that. That's really what takes place as a result of your budget versus the President's budget and what not.

MR. FILNER. With that attitude, I appreciate what you are saying. We have talked many times about this. I think we have to have a working meeting and let's do it.

THE CHAIRMAN. The Committee will stand in recess for a vote.

[Recess.]

THE CHAIRMAN. The Committee will come to order. I will go to Mr. Bradley for any questions he may have.

MR. BRADLEY. Thank you very much, Mr. Chairman.

In the Independent Budget, in the medical care system, and I wasn't expecting to ask the full question, let me see if I can find the citation, page 79.

You talk about seeing a significant increase in the long term care needs over the next decade, in particular, the number of veterans 85 years and older are expected to increase by over 400,000.

Could you just talk about that a little bit, where you see things going with the proposals in the budget?

MR. FULLER. As we did back in the mid-1980s when all of a sudden VA and this Committee saw this huge influx of World War II veterans and started to make plans for caring for the aging veteran.

We were never very successful in doing that, basically because of annual inadequate budgets to try to make changes and so forth. The reports done by the VA called for a huge increase in nursing home beds and services.

We are projecting now, putting myself in the next generation of aging veterans, a huge influx not only from the Korean War veterans' side but also from the Vietnam veterans' side.

I doubt if VA has any long term plans on how to meet this particular demand. I think we heard today their concept in meeting the demand

is to actually shrink eligibility for who are eligible. As the Secretary said, it is about \$400 million in "savings" achieved to enhance the services for those veterans who remain behind.

Historically, when we have seen this happen in changes in eligibility, you only have to wait for the next budget cycle, and our dear friends at OMB say well, you are not treating this many veterans so you don't need that money and they take it away from you.

I think speaking from an organization that represents people with very serious disabilities, a nursing home's the last place in the world you would want to see an individual placed. Alternative institutional care is something that we have followed very, very closely. As the Secretary said, it's the most humane way to do it.

What we need to be careful about, however, is that we don't say that is the panacea for the entire problem. We have paraplegics and quadriplegics who cannot be taken care of effectively at home. The VA nursing homes have been the safety net in this process. It's very difficult to place people like this in the private sector, in a contract nursing home. They just won't accept them there.

What we are trying to show here is that we need to move forward in improving long term care programs because there is going to be anticipated external demand.

MR. BRADLEY. Do I still have more time? I can't see the light.

THE CHAIRMAN. Yes.

MR. BRADLEY. The second question, you talked about the enrollment fee and the co-pays for priority 7s and 8s. I have to admit, I worked my way through a lot of this material and read it, but I didn't see any description of the category 4, paraplegics that you talked about. Perhaps you could talk about that a little bit more on the numbers again.

MR. FULLER. Care was taken in order to give a higher priority to those with catastrophic disabilities, who needed specialized services that they would only find in VA. The statute allowed them to be enrolled as a category 4, which gave them some protection from the Secretary's authority to dis-enroll people. He could actually dis-enroll people in category one through eight if he wanted to under the statute.

But, it gave them higher level of protection and also ensured they maintained access. Subsequent to that, because of the way the statute was drafted, the VA and General Counsel's Office in VA made the determination that while they were enrolled as category 4s, those who had higher incomes and would qualify as being either category 7 or 8 would still have to pay all the co-pays, all the fees, the outpatient fees, the inpatient fees, the prescription fees and everything else.

These are very high end users of the system. A quadriplegic or paraplegic has multiple prescriptions, catheters, bowel equipment, pads, skin care, all kinds of things. We have presented this informa-

tion to this Committee in the past. That comes to a big bill, a huge monthly bill, which could be hundreds of dollars.

We are seeing in some same cases, it might become so burdensome that the individual leaves the VA system and its specialized care and spinal cord injury centers and tries to find a cheaper way to get his health care and he gets himself into real medical trouble.

That was something that we thought we would bring up to the Committee. Everybody keeps saying it's only 7s and 8s and this others groups, people including service connected, the indigent and those with special needs are in a somehow higher category. I just thought it was important to bring that up.

MR. BRADLEY. That affects about 2 million?

MR. FULLER. The imposition of the increased co-pays and the \$250 enrollment fee affects 2 million enrollees in category 7 and 8. Two million people would be affected.

THE CHAIRMAN. Mr. Fuller, I am glad you gave that explanation. I believe it really defines the compassion of a nation when they permitted those category 4s and specialty needs. You are absolutely right. That is very, very expensive, and it's a cost for which the VA said we are going to absorb. Would you concur?

MR. FULLER. I would certainly agree. I think the VA has shown they can provide certain types of specialized services. If you look at care for amputees, care for people with spinal cord injuries, care for blinded veterans and so forth, I think it is only natural that VA would lead the nation in these and spinal cord injury care as well.

THE CHAIRMAN. My point is when we absorb that cost, that really also helps define the compassion of the nation. I don't hear that very often. I think it does.

I really get going whenever I see inequities. I like fairness. This conversation that is happening here in Washington with regard to the death gratuity, I'm just curious for your personal opinions.

These proposals that are headed this way, the death gratuity will end up in the Armed Services Committee, which Mr. Evans sits on, and this Committee would have any Servicemembers' Group Life Insurance piece of that.

You are right. We have a burial piece for which The Independent Budget recommended an increase from the \$2,000 to \$4,000. There is a death gratuity to help remediate expenses, some for burial, for those who do not choose national cemeteries, and we have the SGLI piece.

Now there has been this eagerness to put our arms around the veteran and the family and further define compassion. What about \$100,000 if someone dies in the combat theater?

What I ask of you is that in the military, it is all about a team; it is the team concept. When we do that, we recognize that it can be anywhere from five to seven to one ratio of support personnel to put one

combatant in the theater. The theater combat operations has even changed. You could have someone loading a bomb on a B-2 bomber in Missouri and the bomb drops and kills him, but he's not in theater, or he went to the theater and came back.

It's always changing. We have always been fair. I understand the Marine Corps has come out now and opposed it because they wanted everyone to be treated the same. They don't want to say well, since you were in combat, therefore you should be treated differently than someone who wasn't, yet that guy in combat wouldn't be successful had he not been trained right, and the logisticians had not done their job.

We recognize in the military, for the Army, you wear your combat patch. That is a sort of in your face. I was there, you weren't. You have ribbons that you earned. Then there is this feeling by those who didn't go to the war that somehow they are placed at a disadvantage.

I'm just curious about your thoughts with regard to some of the proposals that are bouncing around, and include your thoughts on SGLI, please.

MR. CULLINAN. Mr. Chairman, representing the Veterans of Foreign Wars, we certainly understand the impulse to provide a greater benefit to the survivors of those who were killed in combat.

We have to agree with what I believe you are saying, it should be fair. It should be equal across the board. You could have an individual who was killed while loading a bomb or performing some other task essential to successfully carrying out a combat operation.

It should be equal. It should be across the board. I understand the impulse though.

THE CHAIRMAN. Do the other gentlemen concur with the testimony of VFW?

MR. JONES. Philosophically, it is correct to provide that benefit to all military individuals, their families, those folks who were killed in service to country. It is the value that they give to that service that we should recognize. There is no way we could possibly repay the family for its loss, but a loss in training, a loss in combat is a loss to a family of an individual who served this country and helped defend its cherished freedoms.

THE CHAIRMAN. Thank you. With regard to this question on category 4, I don't know what the Committee is going to do yet with regard to our budget views and estimates. If in fact we say we are going to cure this inequity between the active duty and those who may have only served one tour, and create an enrollment fee along with a deductible.

If we were to exclude the category 4, would there be any objections from anyone?

MR. CULLINAN. Mr. Chairman, we absolutely do not object to that

provision, protecting those severely disabled veterans. I'd like to say something else about that.

The vast majority of those who have served this nation in uniform did not make it a career, I think 90 percent or something like that. Among those, you have those who saw Omaha Beach, Korea, Vietnam. Today we have Iraq, Afghanistan.

On the other side, we have those individuals who chose to devote a portion of their lives to military service, a military career. Among those, there are those who have not seen combat.

While both accomplishments are valuable and important, we have a problem distinguishing between the worthiness of their respective services.

What I am saying is we object to the enrollment fee and the co-pays.

THE CHAIRMAN. Am I to then assume that you do not see an inequity between charging the deductible and enrollment fee with TRI-CARE for military retirees, versus someone who only served one tour of duty?

MR. CULLINAN. They have certainly earned the Tri-Care for life package. On the other hand, the category 8 veterans in the main are not wealthy individuals. Category 7, although their incomes may come above the national poverty threshold, they are not rich people. They need the help and the care that VA provides. They have come to rely on it.

In that sense, no, we do not perceive - it's a question of need.

THE CHAIRMAN. You do not perceive that as an inequity?

MR. CULLINAN. No.

MR. JONES. Sir, it seems to me we are continuing to speak of these priority veterans from an economic framework, those with income above \$24,000. I think it is important for us to understand that these are the soldiers, sailors, airmen and Marines who walk the patrol somewhere in Iraqi or elsewhere across the globe. They are the heroic men and valiant women who answer our nation's call, and with God's grace, they return from service whole and able to continue their lives without disabling injury or illness.

As we speak, these warriors may be replacing a buddy who yesterday gave the ultimate sacrifice. Today, these patriots are ready to take their place voluntarily in defense of freedom and our way of life.

The members of AMVETS, in regard to your question, believe that these men and women whose future income may exceed an income threshold which currently serves to deny them future health care eligibility should be able to seek care at VA if they have the need following their military service.

It is the least our nation can do to those on whom America depends to defend her liberty. That is AMVETS' position on that question,

sir.

THE CHAIRMAN. Mr. Jones, it also is in the statute as needs and means. Isn't that correct?

MR. JONES. Needs and means. Absolutely.

THE CHAIRMAN. We are very challenged by the growing number on 7s and 8s versus the priorities that we face. We recognize that and talked about that in Charleston; right?

MR. JONES. Yes, sir. I would say as far as AMVETS goes, we would be happy to give our place, an 8 or 7, would be pleased to give their places as long as it is part of the deficit package that has been combed for lesser priorities.

Let me give you one example of the problem we face right now. Last year in the Omnibus Budget Reconciliation Act, was placed a four year \$1 billion program to provide health care to illegal aliens. At the same time, we are talking about pushing 1.1 million 7s and 8s out of the system with a higher co-pay and with a doubling of prescription marks. It is an user tax on veterans who defended the country, and yet we are providing \$250 million a year over the next four years to provide health care for illegal aliens.

That is the problem with the priorities here, sir. The box that we are in is an OMB box. The box needs to be more broad. There needs to be some wisdom in the budget process to comb these things out.

THE CHAIRMAN. The box that we are in is the box which we constructed. Mr. Evans?

MR. EVANS. I want to thank the panel and the Independent Budget proposal you have presented. Thank you.

THE CHAIRMAN. Thank you, Mr. Evans. I want to thank you for the time that you put into the budget submission. We look forward to working with you. There are many areas on which we agree and find common interests. We look forward to continued work.

MR. FULLER. Mr. Chairman, if I could just make just one quick final comment. We will give you as requested the format of how we develop our budget. I think it would be helpful for the Committee and for everyone if you requested VA to give you their process as well.

THE CHAIRMAN. I already have, Mr. Fuller.

The second panel has now concluded. We would ask the third panel to come forward. We would like to thank our final panel today.

We have Major General William M. Matz, Jr., U.S. Army retired, president of the National Association for Uniformed Services. Peter S. Gaytan, director, National Veterans Affairs and Rehabilitation Commission, American Legion. Colonel Robert F. Norton, U.S. Army retired, deputy director, Government Relations, Military Officers Association of America.

General Matz, please begin.

**STATEMENTS OF WILLIAM M. MATZ, JR., PRESIDENT,
THE NATIONAL ASSOCIATION FOR UNIFORMED
SERVICES; PETER S. GAYTAN, DIRECTOR, NATIONAL
VETERANS AFFAIRS AND REHABILITATION COMMIS-
SION, THE AMERICAN LEGION; AND ROBERT F.
NORTON, DEPUTY DIRECTOR, GOVERNMENT RELA-
TIONS, MILITARY OFFICERS ASSOCIATION OF
AMERICA**

STATEMENT OF WILLIAM M. MATZ, JR.

MR. MATZ. Mr. Chairman, on behalf of the members of the National Association for Uniformed Services, I want to thank you for this opportunity to present our views on the proposed budget for the Department of Veterans' Affairs for fiscal year 2006.

I would also like to begin by thanking you, sir, for inviting NAUS to participate in the veterans' summit that you organized at the Citadel last week. This meeting in my view established a great foundation for our future relationship with you, with your Committee subchairmen, and also your staff. We also appreciated the willingness during that summit to listen.

One of the issues brought up at that meeting, and I think everyone was in agreement with, is the urgent need for seamless transition. There has been a lot of very good dialogue here today on that.

This is the seamless transition for our active duty and our Reserve personnel as they depart DOD medical care and transition into the VA medical care.

Recently, I had a personal meeting with the Commandant of the Marine Corps in his office as part of my catching up here just taking over as the president of this association.

During that meeting, he emphasized to me the importance of taking care of the most catastrophically disabled during this transition to veterans' care.

Accordingly, our first priority here with our association is to help you, sir, and your Committee to continue your efforts toward this seamless transition, not only for the catastrophically disabled, but also for all eligible veterans.

We think we can achieve this by implementing the following, and I will simply give you two recommendations.

First, we need to develop an electronic medical record. This record will be the cornerstone of any seamless transition initiative. In today's world of technology, it makes no sense from my perspective that a Service member still needs to hand carry a paper record for four, five, or 20 years, and then upon discharge, have the record sent to paper archives, then have to start a whole new record when he shows up at the VA.

Secondly, we need a single stop separation physical examination. A Service member takes a physical exam when he is discharged. In some cases, just days later, they have to take another physical to qualify for benefits in the VA system.

As part of this single stop examination, we are also recommending the need to expand VA's benefits delivery at discharge, the BDD process, which also was discussed earlier today. Expand that to all discharge locations in making a determination of VA benefits before separation.

I think where we have this discharge process now, it is working pretty well. My members tell me it is working well where it is.

Clearly, this will allow more disabled veterans to receive their benefits in a timely manner.

I think we must of course be realistic, that during the time of budget deficits and with the country at war, dollars for all government programs are tight. We feel the funds for care and support of our veterans is money well spent.

Some government officials have stated recently that providing earned benefits for those who have served is hurtful. In reality, from my perspective as an infantryman for 32 years, taking care of veterans is helpful to the nation's cause. Also, in my view, I think it will enhance the recruiting efforts of our Armed Forces.

Retired military and veterans can be among the best recruiters if they can report their promises were kept after their service was over. Also, from my perspective, it could have the opposite effect if veterans don't receive their promised benefits.

We worked hard on our written testimony and it expands in detail where a plus-up of funds for the VA is needed. I would enjoin all of you to please read that.

In closing, we need to continue our efforts towards making the transition of our departing troops as seamless as possible, and we need to keep the promises to those who have served to ensure they will continue, from my perspective, to be among the very best recruiters when our country needs a strong Armed Forces.

Thank you, sir, and the other members of this Committee for your past and your ongoing efforts. We look forward to working with you as we work through this year.

[The statement of William M. Matz, Jr. appears on p. 114]

THE CHAIRMAN. Thank you for your testimony.
Colonel Norton?

STATEMENT OF ROBERT F. NORTON

MR. NORTON. Thank you, Mr. Chairman and Ranking Member, Congressman Lane Evans, and distinguished members of the Com-

mittee, for the opportunity to appear before you today on behalf of the 370,000 members of the Military Officers Association of America.

First, Mr. Chairman, I want to congratulate you on your appointment as Chairman. We look forward to working with you and your new Subcommittee chairs. I also want to say on behalf of our national president, Admiral Ryan, thank you very much for the opportunity to participate in last week's meeting at the Citadel. It was a very useful opportunity for us, and we really greatly appreciate the time that you committed to that, to dialogue on veterans' issues.

I will address three issues from my prepared statement, and ask that the full text be entered into the official transcript of today's hearing.

First, MOAA strongly supports full funding for the VA health care and claims processing systems. With tens of thousands of new veterans returning from combat zones every day and future veterans being deployed every day, now is not the time to cut back on VA health care, or to accept continued lengthening of the disability claims backlog.

A nation that can provide an \$82 billion supplemental to prosecute the war must be able to provide for the needs of those who have borne the battle and their families.

MOAA recommends, as did the Presidential Task Force, that the Committee support full funding to meet the rising demands in VA health care.

Second, MOAA believes much more needs to be done to help Service men and women and their families to make a smooth transition from the Armed Forces into the VA.

The hand-off between DOD and VA is still plagued with inefficiencies that affect active duty troops, mobilized National Guard and Reserve soldiers and their families. Action on seamless transition has not lived up to the talk, Mr. Chairman.

During this time of war, we really need a "Manhattan Project" to complete action on electronic medical records, VA disability claims filing before discharge, an one stop separation physical, and electronic DD214, and tracking of military occupational exposures.

For years now, rhetoric has far out paced action, and we have made very little progress towards these goals. We need greater pressure on the Defense Department and the VA to get this fixed now so our veterans will get better access to care and services, and the government can finally realize the projected savings.

Thirdly, MOAA recommends restructuring and improving the Montgomery G.I. Bill. Our forces in the field, active duty Guard and Reserves, operate as a total force, but the G.I. Bill is built on an outmoded Cold War platform that sets a firewall between the active duty and the Guard and Reserve G.I. Bill.

If active duty benefits are raised for the G.I. Bill, the Reserve program should be raised proportional to the active duty rate. There are

huge challenges ahead in recruiting for all components, active, Guard and Reserve. It will be essential for this Committee and the Armed Forces Committee to improve and integrate both G.I. Bill programs.

My prepared statement outlines initiatives that we believe are needed now to modernize the G.I. Bill for the 21st Century force.

Thank you again, Mr. Chairman, for the opportunity to testify today. I look forward to your questions.

[The statement of Robert F. Norton appears at p. 120]

THE CHAIRMAN. I thank the gentleman.
Mr. Gaytan?

STATEMENT OF PETER S. GAYTAN

MR. GAYTAN. Thank you, Mr. Chairman. Thank you for the opportunity to express the views of the 2.7 million members of The American Legion regarding the Department of Veterans' Affairs 2006 budget request.

The American Legion urges this Committee to fund VA at a level that will ensure all veterans have access to the VA health care system. The VA budget must reflect the true demand for care.

The American Legion is concerned about the impact of certain proposals included in the fiscal year 2006 budget request that seek to generate increased revenue for VA from the pockets of veterans instead of through allocation of Federal funds.

The American Legion opposes the implementation of a \$250 annual enrollment fee for non-Service connected priority group 7 veterans and all priority group 8 veterans. This newly imposed fee would simply charge currently eligible veterans without providing any guarantees of improvement in access to care at the very system created to treat their unique needs.

The American Legion would urge Congress to once again reject this proposal just as it did last year.

While the American Legion applauds the initiatives to eliminate co-payments for hospice care, to exempt former POWs from co-payments, and for VA to pay co-pays for emergency care for enrolled veterans at private hospitals, we do not support increasing the pharmacy co-pay from \$7 to \$15 for priority 7 and 8 veterans.

While the American Legion realizes the importance of adequately funding VA, we support other options that would create additional revenue streams for VA, such as Medicare reimbursement.

The American Legion would rather the VA seek reimbursement for CMS for all enrolled Medicare eligible veterans being treated for non-Service connected medical conditions before trying to balance a budget on the backs of priority groups 7 and 8 veterans.

The American Legion recommends \$34.1 billion for VA medical

care. The American Legion continues to advocate for all MCCF collections to be added to the budget numbers and not be treated as an offset to the budget.

The American Legion opposes restricting eligibility for state veterans' homes per diem payments for long term care to veterans in priority groups 1 through 3 and catastrophically disabled priority group 4 veterans.

The state veterans' homes have been a successful cost sharing program between VA, the states and the veterans. Veterans in state veterans' homes tend to be without family, indigent, requiring aide and assistance. This proposal would spell financial disaster for those homes and would result in a new population of homeless elderly veterans on our streets, especially in those states with poor Medicaid nursing home reimbursement rates.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent of the costs of nursing home and domiciliary care provided to veterans in state veterans' homes, and full reimbursement for veterans with 70 percent or greater Service connected disabilities.

The National Association of State Veterans' Homes and VA should develop mutual planning efforts, enhance medical sharing agreements, and enhance use construction contracts with qualified providers.

Mr. Chairman, the American Legion is fully committed to working with this Committee to ensure that America's veterans receive the entitlements they have earned.

Thank you again for the opportunity to be here today.

[The statement of Peter S. Gaytan appears at p. 131]

THE CHAIRMAN. Thank you. I appreciate your testimony.

As I opened with other panels, gentlemen, I would like to know where you were when you took your oath either in enlistment or commissioning.

MR. MATZ. I was commissioned through the ROTC program at Gettysburg College, and it was 4 June 1961 at Gettysburg College.

THE CHAIRMAN. Thank you. Colonel Norton?

MR. NORTON. Mr. Chairman, I entered the Army from Brooklyn, New York at Ft. Hamilton on October 19, 1966, and a little over a year later, I took my second oath as a commissioned officer on August 27, 1967 at Ft. Benning, Georgia. At that time, the Benning School for Boys.

THE CHAIRMAN. Right.

[Laughter.]

MR. GAYTAN. I actually enlisted on July 17, 1991 in Richmond, Virginia in the Air Force.

THE CHAIRMAN. Very good. Thank you.

You can do that on your time. He would like to know when your discharges occurred. I will let you cover that.

Gentlemen, I would like your thoughts. You were here, were you not, when I asked the second panel questions with regard to the death gratuity, its impact upon the total force and the team concept which we have in theater versus those out of theater. I would appreciate your personal thoughts on the issue.

MR. GAYTAN. I can speak for the American Legion. We as well as the VFW understand the urgency to increase the death gratuity. You brought up the fact that it may be an inequity and how it is awarded to individuals.

Knowing that the American Legion is a veterans' services organization and we are run with organizational resolutions, since attention has been given to the increase in the gratuity benefit, the American Legion is considering that. Your point of view will be taken into consideration.

What you brought up brings a new facet to our debate over support of the increase in the death gratuity and the fairness of that. The American Legion is still developing an organizational opinion on exactly which direction that desire to improve the payment for a death gratuity should be directed.

Mr. Norton. Mr. Chairman, this issue really is about the families left behind. As all of us have experienced in recent years after 9/11 with the loss of our brothers and sisters in combat, there were also losses from military training and other accidents.

The families that are left behind, and as you know, most of the force today is married, have to adjust to this enormous burden of grief and get their lives back together. To make artificial distinctions about deaths in combat zones as opposed to other aspects of military service is artificial, and this really does a great disservice to these families whose wives, sons, daughters, et cetera, have given the ultimate sacrifice to our country.

MR. MATZ. Clearly, sir, an increase in the death gratuity is needed, number one.

Number two, I guess to second my colleagues here, death is death, whether it is on the battlefield or whether it is someone who is serving at Ft. Benning and something happens. We as an association, and I honestly cannot say I've gone out and polled all my 180,000 members, but in anticipation of this question, I did do my best to try to get a feel from them and sort of see what the reaction would be if it did not go to everybody, so clearly our association is with these two folks here.

We feel if it is going to be increased, it is about the families and it should be increased across the board.

THE CHAIRMAN. Mr. Evans, you are now recognized for any ques-

tions you may have of this panel.

MR. EVANS. I just want to thank them again. We appreciate you. Thank you, Mr. Chairman, for holding the hearing again.

THE CHAIRMAN. Thank you, Mr. Evans. Mr. Bradley?

MR. BRADLEY. Thank you again, Mr. Chairman. It's been a great hearing.

Not a lot of attention has been paid to prosthetics issues and research this morning and now this afternoon. The Independent Budget, I believe, recommends a \$67 million increase over the President's submitted budget.

Given the 10,000 injuries that we are experiencing in Iraq and a lot of soldiers are coming home with injuries that they would not have survived in past conflicts, and that involves also the limb, would you care to comment on that issue, any of you?

MR. GAYTAN. I can comment for the American Legion, aside from the Independent Budget's recommendation. If you look at the full testimony from the American Legion, our staff, and this may come in line with your question earlier, Mr. Chairman, about developing our recommendations for the budget, our staff analyzes the prior budgets, takes into account the inflationary increases in medical costs, and also the anticipated influx of veterans.

With the war going on, as you mentioned, and the advances in battlefield medicine and battlefield care and the armor that is being worn by these individuals, in past wars, those lives may have been lost on the battlefield, where those individuals are coming back with life altering disabilities due to those improvements in protection.

The American Legion recommended an increase for medical prosthetics research as well, equivalent hopefully to the impact of those veterans returning from Iraq and Afghanistan.

MR. NORTON. I would only add, sir, that I've been to Walter Reed and I've seen some of the amazing technologies that have been developed and are being developed for those who are wounded in the conflicts in which we are involved today.

To me, there is really not enough that we can do for these great young heroes that come back wounded in mind or body. As Pete indicated, there is an enormous opportunity to further refine and develop these technologies to restore as much function as possible.

A robust prosthetics budget is very, very important to those who have really suffered horrifically in these conflicts.

MR. MATZ. I would concur wholly with that. Another point I would bring out, as you know, so many of these young men and women who are being hit with these IEDs, it's a dirty infantry war over there, they are losing their limbs but they are coming back here. They are being rehabilitated and they want to stay in the Service. They want to continue to serve for you and I. The Service wants them.

Whatever you can do to increase that budget for these prosthetic

devices, I would encourage it.

MR. BRADLEY. Thank you, Mr. Chairman. I yield the balance.

THE CHAIRMAN. Thank you. I would also, as I asked the last panel with regard to the Independent Budget, ask the American Legion the same question, since your testimony was an exact number. You recommended \$31.4 billion with regard to health care. I would like for you to submit to the Committee, and as a matter of fact, as soon as possible, because we have until the 23rd to get our budget submission, I would like to know the methodology and your modeling with regard to your tables and how you made your predictions, assumptions, and estimates, to come up with this number of \$31.4 billion, please.

MR. GAYTAN. Yes, sir.

THE CHAIRMAN. With regard to the testimony of the Secretary and you have heard my remarks, with regard to what I refer to as an inequity between the active duty who are charged the higher co-pays, deductibles, enrollment fees, than someone who may have only served one tour of duty, do any of you gentlemen have an opinion?

General Matz, do you think that is an inequity or do you think it is not?

MR. MATZ. First of all, and we have talked about this, the issue on the 7s and 8s. I'm just getting into this. I believe that when we were bringing the 7s and 8s into the programs, they were really strongly encouraged to come into it.

My feeling and our association's feeling is we made them a promise. We should not go back now and charge them the \$250 just to enroll in a program, and increase the pharmacy co-pay.

Our position is we should not touch that. However, what the Committee might want to consider is if you open it up again, if it's opened up again to other 7s or 8s, you might want to address it with those people. However, those people who are currently in the program now, the 7s and 8s, should not have to pay this additional fee.

MR. NORTON. Mr. Chairman, I think you addressed part of this earlier. You made a comment, I think you made reference to whether there should have been enrollment fees done back when when eligibility reform was enacted.

As General Matz indicated, when open enrollment was implemented in 1998, which started the open enrollment era, that continued through two Administrations, four years running, and those folks came under a certain set of "rules and engagement," if you will.

We feel it is unfair at this point to go back and change the rules on them. They were folks who were invited into the VA to help the VA transform itself from a hospital based system then to a comprehensive outpatient based system today.

We don't think it is fair to turn around and transfer the responsibility for funding the care that they came into the system onto their

backs.

I would also say, too, Mr. Chairman, if I might, that we are really not in the business of pitting one group of veterans, retired veterans, against other veterans. We just simply don't care to go there.

THE CHAIRMAN. Colonel Norton, we have a problem. We have a problem, gentlemen. Whether you want to say it or whether we want to dance, we have a military retiree that is waiting in that waiting area but has to pay that enrollment fee and higher co-pays and deductibles versus someone whom may have only served one tour of duty.

I just want you to know, we can talk about it, we can do the forensics of it, but I just throw out we have to cure something that we have in front of us.

MR. NORTON. A substantial number of these veterans, 7s and 8s, Mr. Chairman, as you know, are Medicare eligible. They have paid into Medicare over a life time of work. It seems to us that a more practical long term sustainable way to take care of them in terms of non-Service connected conditions, would be to allow them to use their Medicare benefit in the VA health care system.

THE CHAIRMAN. I have been an advocate of co-pays and deductibles for a long time. It is about modulating the utilization rate. People can say whatever they want about why we use them. I've heard that testimony here today.

I just want you to know as I do my oversight over health systems, that is what we do. You both belong to very strong organizations, along with some others, who helped me when I created TRICARE for Life. I didn't have any pushback with regard to co-pays and deductibles.

We conclude this third panel. I ask unanimous consent for general leave for members to submit opening statements and questions for the record within five business days.

This will complete our hearing. We thank you for your testimony.
[Whereupon, at 1:36 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN BUYER

Mr. Secretary, I am glad you can be with us today to share with the Committee the President's proposed budget for 2006.

Those of us on this Committee take very seriously our responsibility to ensure that VA provides the highest quality of health care for those who are enrolled now and those who will enroll in the future. We are honored by the trust placed in us by our respective caucuses. Capitol Hill can be a very partisan place. But when we walk through this hearing room door, we leave labels and partisanship outside.

That does not mean we always agree. We do not. But we communicate—sometimes it is hard—but we work together so that we can provide the best possible services to those who have left freedom in their footsteps.

Our guiding principles are no different than of those who served. Last Friday, I held an offsite meeting with many Veterans and Military Service Organizations in Charleston, South Carolina, on the campus of The Citadel.

We discussed how and where each participant who served in the military took the oath of enlistment or commission.

The Vice Chairman of this Committee, Mr. Bilirakis, can remember where he took the oath in the Air Force.

Mr. Brown can recall where he took the oath for the South Carolina National Guard.

The same is true for Mr. Evans in the Marine Corps. or Corporal Vic Snyder who served in Vietnam with the Marines.

Service in the Armed Forces does not make one person more patriotic than another. We all serve this country in different ways. One might have a father who served and now work on behalf of veterans in a VSO. Another may not have served in the military but serve here in Congress and took their oath across the street.

Mr. Secretary, I am sure you, too, can recall where you took your oath. I hope you will share that with us.

Those who serve have instilled in them certain values—military values:

Navy and Marine Corps: Honor-Courage-Commitment

Army: Loyalty-Duty-Respect-Service-Honor-Integrity-Courage
 Air Force-Integrity First - Service before self - Excellence in all that we do

Coast Guard: Honor-Respect and Devotion to Duty

Merchant Marine: Integrity from within – Respect for others – Courage in adversary – Service above self.

On Friday at the retreat, we all agreed that these are the same values in which we serve now and which define our commitment to care for those veterans with service-connected disabilities, those with lower incomes, and those with special health care needs.

It is our job to receive this budget today, to listen and learn about how this Administration seeks to better the VA and ensure that our health care resources continue to be concentrated on care for enrolled veterans most in need of VA services, to make certain that our research continues to push the bounds of science in prosthetics, hearing and so on, to have a seamless transition from DOD to VA, to provide for the timeliness of compensation and pension claims, and to make sure that those men and women who come back receive not just governmental assistance but receive an opportunity to live.

Mr. Secretary, several weeks ago we met and discussed these very same issues. We talked about how our role is not to provide just government assistance. Many of us have been to Walter Reed or Bethesda. We know first hand the significant challenges those men and women face. Some will need mental health, some will need physical therapy, and some will need to learn to walk or throw a ball.

We stand in amazement at their sacrifice and those willing and eager to join back with their unit. For those who cannot go back but instead go home....it is our job to make sure they have the ability to go home and be productive members of society and to live their life. To have every opportunity to succeed.

Mr. Secretary, I know from our conversation that you will join Mr. Evans, this Committee and me in this endeavor to make the VA the best it can possibly be.

I thank you again for your service to country both as a Ranger and for answering the call of this President as Secretary of Veterans Affairs. I look forward to hearing your testimony today and working with you in the future.

PREPARED STATEMENT OF CONGRESSMAN EVANS

"It is a sign of how desperate the Bush administration is to protect tax cuts for the wealthy while also trying to reduce runaway deficits that it would call for veterans to pay more for their health benefits. Congress should reject this proposal out of hand and put enough money into veterans' health care to end the inexcusable waiting lists at many veterans' facilities."

-- editorial, *Boston Globe*, Feb. 9, 2005

**Statement of Rep. Lane Evans
Ranking Democratic Member
House Veterans' Affairs Committee
Before the Full Committee Hearing on the
President's FY '06 Budget for the Department of Veterans Affairs
February 16, 2005**

The budget submitted by the White House to this body on February 7 is one of the most dishonest, disingenuous, and insensitive documents I have seen in over two decades in Congress. While attempting to hide "off-budget" the true impact of its Social Security privatization proposal, its tax cuts for millionaires and, perhaps most astounding of all, the costs of the wars in Iraq and Afghanistan, the Bush Administration arrogantly dismisses the exorbitant costs of its agenda.

Taken together the Administration's priorities will contribute to a deficit almost beyond comprehension that will saddle current and future generations with trillions of dollars of debt. Under the Administration's agenda, a 10-year surplus of \$5.6 trillion projected in 2001 will become a \$3.9 trillion deficit – a deterioration of \$9.5 trillion with which we, our children, and our children's children will have to struggle.

To pay for its costly agenda, the Administration wants to cut services for Americans across the spectrum. But nowhere is its arrogance more evident than in its failure to recognize the sacrifices of those who have worn this country's uniform and their families. In his State of the Union message, President Bush saluted the bravery and sacrifice of our troops abroad. He also said that this grateful country will do everything we can to help them recover. The flat-lined budget he has proposed, which devastates programs for America's veterans, instead makes a cruel mockery of his own rhetoric.

The Administration's budget not only severely shortchanges the nation's sick and disabled veterans, seeking to force hundreds of thousands of additional deserving veterans out of the VA health care system and commencing the abandonment of its long-term care obligation, among other things, it does so – shockingly – at the height of a war that will create hundreds of thousands more veterans who will need the system today, tomorrow and years into the future. On the issue of veterans' benefits, this Administration has lost its moral compass.

For fiscal year 2006, the Bush Administration requests a scant 0.5% more than Congress recently appropriated for the VA in fiscal year 2005. This will force the Department of Veterans Affairs to sustain and broaden a practice of rationing care to veterans that has been a hallmark of the Bush Administration.

Under the Administration plan, without collections, VA medical programs would receive a 0.4% increase over the funds appropriated for fiscal year 2005, ignoring the 13-14% VA itself has testified it needs annually to even maintain a current level of health services. When excluding the Administration's proposed new fees and increased copayments, proposals we Democrats on the Committee will adamantly oppose, the budget also falls well below the amount the Congressional Budget Office estimates VA needs to maintain purchasing power at the 2005 enacted level.

The bottom line is that this budget is at least \$3.2 billion short in discretionary funding just to keep the VA ship afloat without forcing one veteran to pay for another veteran's care.

For the third straight year, the President's budget would have Congress impose a \$250 annual enrollment fee for medical care on Priority 7 and Priority 8 veterans (the latter of which can no longer enroll for VA care under administrative edict), and more than doubles the amount they pay for prescription drugs. These are veterans whose conditions are not service-connected and who have incomes above VA means-tested levels. According to the Administration's own figures, this will result in driving 213,000 additional veterans out of the system.

But what is most galling is the Administration's position that these veterans, Priority 7s and 8s, are not deserving of VA care because they are – and this is quite misleading – “higher income” and might therefore have other health care options. This group of veterans, in fact, includes combat-decorated veterans and others who served honorably and whose annual incomes exceed \$25,000 (single) to slightly more than \$35,000 (five or more dependents). A significant number of them lack health insurance (in 2001, 6.4%, but likely more as the number of uninsured Americans continues to grow), and some are not eligible for Medicare.

In the private sector these veterans are not going to receive the veteran-sensitive, specialized treatment that VA can provide. Without VA, some will fall through the health care cracks altogether. Moreover, many in the veterans' affairs community have serious concerns that the VA health care system may not remain a viable independent system without these veterans as patients, so *all* veterans may be adversely affected by such policies. The Administration's push to oust deserving veterans from the system also endangers VA's other missions of educating the Nation's health care professionals, conducting research and serving as back-up to the Department of Defense in the event of war.

The Administration's intention to weaken the VA health care system is further clarified by its call for a staff reduction of 2% in its medical care business line. That amounts to the removal of more than 3,000 health care employees, mostly nurses, at a time when there is, in fact, a nursing shortage in VA.

The Bush Administration's budget proposal would eviscerate VA's nursing home program and state home nursing care programs. The budget seeks to repeal the law that requires VA to maintain a certain level of long-term care beds in its own facilities. It halts funding for state grants for critically needed extended care facilities and reduces by 61% the census it supports in existing state homes by reducing per-diem payments.

The Administration proposes to limit eligibility for nursing home care in all of its venues. This could be particularly problematic as States, which are already struggling with long-term care costs, attempt to rein in their programs. Persons over the age of 85 are those most likely to need long-term institutional care. The number of veterans over age 85 is expected to double in the next eight years. The Administration wants to pull the rug out from under our oldest veterans right at the peak of their need for long-term care services. These cuts will leave older and less severely disabled veterans with no place to go.

The President's budget request also requires VA to identify and implement a total of almost \$1.8 billion in so-called "management efficiencies," and to use these phantom efficiencies to offset health care funding. It remains unclear where or if VA officials are finding these "efficiencies." Here's how this smoke screen works: 1) pick a savings amount, any savings amount; 2) deduct the amount of the projection from the budget; and, 3) call it increased funding when, in fact, it doesn't materialize and its effect is to further limit access to care.

As troops return home from Operation Iraqi Freedom and Operation Enduring Freedom, VA will eventually become responsible for many of their health care needs,

particularly for those with injuries that may last a lifetime. Many of these servicemembers will require ongoing rehabilitative care for their injuries -- both mental and physical. As of December 2004, VA had treated roughly 32,684 of the 210,000 veterans from these deployments. We agree with the Independent Budget on the necessity of a significant infusion of funds to ensure that veterans are able to receive the best sustaining care available for their problems.

Recent studies have shown that a significant number of returning troops (up to 17% or more) are demonstrating a need for post-deployment mental health intervention. Troops' mental health issues range from acute and transitory anxiety and readjustment disorders to more chronic and severe problems, even psychoses. We believe VA must stand ready to provide immediate relief to servicemembers who return requiring its services. Experts indicate that immediate intervention may be the surest remedy to preventing some long-term and chronic disorders.

The President's budget also cuts \$9 million from VA's renowned medical and prosthetic research program, whose achievements have benefited veterans and non-veterans alike. As advocates are quick to point out, without appropriated research dollars, these programs fail to draw competitively based funding from private and other government sources. With continued cuts to its appropriated funding levels, the system continues to be challenged to fund merit-reviewed projects that could greatly benefit veterans and other Americans.

Under the Bush budget, there are no new initiatives to improve the administration of benefits to veterans. Because over a quarter million men and women of the reserves have served on active duty for the period for which they were called up, they are now eligible for a full range of veterans' benefits.

As thousands of veterans return from the war in Iraq and hostilities in Afghanistan with service-connected disabilities, they are offered service-connected disabled veterans life insurance of only \$10,000 for which they pay excessive premiums based upon an actuarial table that is 65 years out of date. In addition, the surviving spouses of those who have given their lives will receive a transitional benefit of an additional \$250 per month for only two years if they have dependent children under age 18. A VA study of survivors' needs recommended the additional benefit for five years.

At a time when we are asking young men and women to give their lives in service around the world, we must assure that those they leave behind -- their widows, widowers and orphans -- are properly cared for. This budget does not do so.

Veterans should expect to receive an accurate and timely decision on their claims for compensation and other benefits. In its latest budget the Administration claims to add 113 full-time employees to adjudicate veterans' claims for benefits such as compensation for service-connected disabilities. However, the increase is funded with emergency one-year funding and will require VA to freeze hiring before the end of 2006 in order to meet the reduced FTEE level for 2007.

Particularly troubling with the increase in appeals from veterans is the Administration's decision to curtail training and necessary upgrades or replacement of computers. Veterans deserve an accurate decision the first time they file a claim. Without training and appropriate computer upgrades, it will be impossible for veterans to receive the high quality assistance and decisions they deserve.

Moreover, veterans who are appealing decisions to the Board of Veterans Appeals can expect to see a dramatic increase in time to resolve their appeals. Since President Bush took office in 2001, the number of pending appeals has increased from 87,291 to 151,803. Almost 75% of those who appealed VA regional office decisions in FY '04 had those decisions remanded or reversed by the Board of Veterans Appeals. With the reduction in staff proposed for the Board of Veterans Appeals in the Administration's FY 2006 budget, the backlog of pending appeals will continue to grow. It is unconscionable that veterans who are appealing decisions for benefits based on their service-connected disabilities will be required to wait years for a decision.

I hope the Members of the Committee on both sides of the aisle will see the President's budget for what it is – an almost total waste of paper and our time. We must put forth a budget for veterans that bases the bottom line on the needs of those who have worn the uniform, not on satisfying the desires of millionaires to avoid taxes and on other misplaced priorities.

I want to thank the veterans' organizations that, for the 19th consecutive year, have put together a well-researched, well-considered, fully developed and responsive independent budget for veterans' benefits and services. I'd also like to thank those other organizations that have submitted their views and comments and that, universally, have rejected the Administration's budget.

I would like to associate myself with remarks in the prepared statement of one of the organizations that makes up the Independent Budget group: "In place of dollars, we are presented with a budget that relies far too heavily on gimmicks, accounting tricks, and on forcing some veterans to pay for the health care of other veterans ... This is not a lean budget, rather, it is a budget designed to strangle a health care system relied upon by sick and disabled veterans."

**The Honorable Michael Bilirakis
Committee on Veterans' Affairs
February 16, 2005**

**“Hearing on the Fiscal Year 2006 Department
of Veterans Affairs Budget Request”**

Mr. Chairman, I want to commend you for scheduling this timely hearing on the Administration's Fiscal Year 2006 budget request for the Department of Veterans Affairs. I would also like to take a moment to welcome the new VA Secretary, Jim Nicholson, and our other witnesses to the Committee this morning.

Like most members of the Committee, I have been hearing from the veterans in my district regarding the Administration's budget recommendations. I am anxious to hear directly from Secretary Nicholson on the Administration's overall budget request for the upcoming fiscal year and how it addresses the needs of our veterans.

There are a number of issues in the budget which are of specific interest to me, but rather than spending time to raise them now, I will wait until the question and answer period to discuss them.

In addition to hearing from the Secretary, I am also anxious to hear the recommendations of the authors of the Independent Budget as well as those of other witnesses. The veterans' service organizations often provide us with valuable insight into the day-to-day operations of the VA and its needs.

As the representative of a district with a large veterans' population, I strongly believe that we must do everything we can to repay the great debt that we owe the men and women who answered the call to duty. I know my Committee colleagues share my dedication to veterans, but I hope that everyone will keep an open mind on the issues before us today as we listen to our witnesses so that we can work together on a bipartisan basis on behalf of our Nation's veterans. We can accomplish so much more by working together.

As always, Mr. Chairman, I look forward to working with you and the other members of our Committee to ensure that our veterans receive the benefits they earned through their service to our country.

Opening Statement of Congresswoman Herseth
Veterans Committee Budget Hearing
February 16, 2005

Thank you to everyone for being here to discuss the Department of Veterans Affairs budget request for Fiscal Year 2006.

First, I would like to thank the Department of Veterans Affairs for the tremendous work it does on behalf of our Nation's veterans. We owe an enormous debt of gratitude to the men and women who everyday provide health care and benefit services to our country's veterans.

Secretary Nicholson, I want to congratulate you on your recent appointment and thank you for your service to our country. I understand the difficulties of your job and budget constraints your agency is forced to deal with.

While I am pleased that the President's overall budget includes increased pay and funding for our soldiers serving overseas in Iraq and Afghanistan, I do not believe we are doing enough to adequately provide care for these young men and women when they return home.

The wars in Iraq and Afghanistan have created a new generation of veterans. Thousands of these young men and women are coming home afflicted with physical and mental wounds. This influx of patients is putting a heavy burden on our VA hospitals. It is our responsibility to ensure the VA receives the funding it needs to care for this new generation of veterans.

Not only are we not providing adequate funding for our nation's veterans, but the President's budget is once again asking them to pay more out of their own pockets for the services they were promised.

This budget proposal requests authority to implement a \$250 enrollment fee for Priority 7 and 8 veterans and an increase in pharmacy copayments for these same veterans. Many veterans can not afford these extra costs. In addition, I find it difficult to ask veterans to pay more for care that they already paid for with their service.

Finally, in talking with veterans in my state, I have found that many of their concerns deal with the lack of access to medical care. In rural states such as South Dakota many veterans have to travel hundreds of miles to simply reach medical facilities. These rural veterans are often ignored when it comes to debating what is best for veterans' health care. I hope that as we discuss the budget today we do not forget our veterans in rural America who struggle to merely access VA medical facilities and depend heavily on Veterans Community Based Outreach facilities.

The Department of Veterans Affairs has made some tremendous improvements in recent years. However, I believe the budget includes much room for improvement. I look forward to working with my colleagues and the members of the Department of Veterans Affairs to find solutions to these challenges.

I am pleased that we have the opportunity to hear from today's panel and am grateful to have the opportunity to hear your suggestions and answers to many of the challenges and questions facing our nation's veterans. I look forward to hearing your testimonies.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

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Rep. Corrine Brown
Statement for the Record
Committee on Veterans Affairs
FY06 Budget Hearing
February 16, 2005
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Thank you Mr. Chairman.

I appreciate the Secretary coming here to present the budget in person. A budget this poor is usually mailed or phoned in.

Veterans are not a drain on the budget. They are an integral part of our nations defense infrastructure. As the Department of Defense undersecretary for personnel and readiness said, "The amounts [paid to military retirees and veterans health care] have gotten to the point where they are hurtful. They are taking away from the nation's ability to defend itself."

This statement, while made by the Department of Defense, is echoed by the Veterans Administration. The budget you submitted does nothing to address the ban on Category 7 and 8 veterans who served this country and by the grace of god were not injured in their service to their country. They served their country and now cannot get health care.

In fact, you TAX those veterans who come to the VA for health care services and were in the system before you put this policy into effect.

This seems like the same dance we go through every year. Each year you try to impose a tax on veterans to pay for your tax cuts for the wealthy. Each year Congress says no and funding is properly given to veterans health care.

Dead On Arrival. That is what I thought when I saw the \$250 annual enrollment fee and an increase of 114% for the pharmacy co-pays.

According to your own numbers, this will cost veterans over \$2 billion over the next five years and force out roughly 213,000 veterans from the veterans health care system.

We have all these veterans coming back from Iraq and Afghanistan as soon as the stop loss order is rescinded for military personnel, and I do not see any efforts to ramp up efforts to deal with these men and women.

Some of the programs that are negatively affected are:

- VA is currently projecting that it will eliminate 2% of its direct medical care employees (more than 3,000 full-time employees—mostly nurses).
- The Administration is requesting Congress to place a virtual moratorium on state grants for extended care facilities

Rep. Corrine Brown

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- The Administration proposes to eliminate more than half (61%) of the census it currently funds in per diem payments for state homes
- The Administration proposes to limit eligibility for nursing home in all of its venues (VA, community and state) to only the most highly service-connected veterans and those with short-term needs.
- When the CARES program was initiated, it was based on a commitment of \$1 billion a year for new construction. This budget proposes only about ½ of this amount (\$540 million) for major construction for FY 06.
- Medical research is reduced by \$ 9 million
- The budget proposes a reduction in staff at the Board of Veterans Appeals. This will result in longer times for veterans to receive a decision on a claim for benefits which is appealed. The number of appeals pending as of February 5, 2005 was 151,031. About half of these appeals will not be resolved at the regional office level and can be expected to receive consideration by the Board. Last year the Board issued 38,371 decisions, a 22% increase over the prior year. Without additional funding the backlog of claims at the Board will increase. Veterans whose claims were decided within 170 days in 2004 can expect to have the time increased to 391 days by the end of 2006.

Chairman Jeff Miller
FY06 Budget Hearing
Statement for the Record

February 16, 2005

Thank you, Mr. Chairman.

First, I want to welcome you Secretary Nicholson, and thank you and your dedicated staff for all they do for our returning servicemembers and veterans.

Too often, people look to criticize the Department without taking into account all the positive accomplishments you can point to.

Let me talk briefly about the Veterans Benefits Administration side of the VA budget request. It is promising that while the backlog of claims is beginning to decline – albeit slowly – quality is not suffering.

In each of the areas for which my subcommittee has jurisdiction, I note an increase in funding and staff. Although I am certain that some here today will find fault with this proposal, to me this is a budget blueprint that we can work with under our current fiscal constraints.

I am concerned, however, with the amount allocated toward restoration and repair projects at our nation's veterans' cemeteries. The last thing we can do for a veteran is offer a dignified final resting place befitting their military service. As you know, the Logistics Management Institute in 2002 identified more than 900 infrastructure deficiencies at both open and closed cemeteries – at a cost of \$279 million – yet the budget request to this end is just \$14 million. That won't make a dent in the needed repair projects.

I will be submitting questions for the record, and look forward to your responses.

**OPENING STATEMENT OF
LUIS V. GUTIERREZ
HOUSE COMMITTEE ON VETERANS' AFFAIRS
"Hearing on the President's Proposed FY 2006 Budget for the
Department of Veterans Affairs"
WEDNESDAY, FEBRUARY 16, 2004 – 10:00A.M.**

Mr. Chairman, I would like to thank you for holding this hearing to examine the Veterans Affairs budget request for Fiscal Year 2006. I look forward to the testimony of the new Secretary of Veterans Affairs, Jim Nicholson, and the invited panelists.

The Fiscal Year 2006 VA budget request makes it abundantly clear that the Administration believes that taking care of our nation's veterans is not a priority. I certainly cannot support a budget that does not adequately and fully provide for our veterans, and this budget is inexcusable and reprehensible.

I am particularly concerned with the Administration's continued insistence on balancing the budget on the backs of our nation's veterans and their access to VA health care. Again, this committee is faced with a budget request that includes a doubling of co-payments for prescription drugs and instituting a \$250 enrollment fee for Priority 7 and 8 veterans. This is the third year in a row that the President has requested an enrollment fee, and I look forward to working with the committee to ensure that the third time is not a charm for this request. It was bad policy the first time and it is bad policy today.

When the budget request is adjusted not to include an enrollment fee and increased co-payments, the President's request is only .5% above last year's funding level. This virtual flat lining of the budget is an insulting response to the VA's own testimony that medical programs will need a 13-14% annual increase to maintain the current level of service. Early analysis shows that at the President's funding level, more than 200,000 veterans will be pushed out of the VA health care system.

I am also concerned about the message the President's budget sends to veterans in my home state of Illinois. As you may know, Illinois veterans rank 50th in the nation for the amount of benefits compensation they receive.

Unfortunately, the budget request calls for staff reductions at the Veterans Benefits Administration (VBA). It is hard to imagine a scenario where cutting staff provides a solution to the growing disparity in compensation to Illinois veterans.

Equally as troubling is the proposed reduction in staff for the Board of Veterans Appeals. Since President Bush took office, the number of pending appeals has grown from 87,000 to 154,000. Many of veterans living in Illinois who wish to challenge the disparity in compensation they have been dealt, would only be met with longer waits and less attention if the President's budget is adhered to.

Currently, the VA's Inspector General is investigating the benefit discrepancies faced by Illinois veterans. I am sure that the Inspector General will not feel that staff reductions and larger numbers of pending appeals before the Board will provide Illinois veterans with greater equity in compensation. When these men and women come home, they should not have to fight a government agency for disability benefits as hard as they had to fight our enemies abroad. They should be treated as heroes and as patriots. They should get the best services, ample compensation for their sacrifice and the proper appreciation for their courage.

The annual occurrences of under-funding, increased fees and disappointments are all the more reason to move forward with Ranking Member Evans' mandatory funding bill. It is encouraging that a growing number of major veterans' service organizations, many of them here today, are making mandatory funding one of their highest priorities. I hope that we can answer the call of these veterans, much like they so honorably heeded the call to service when our country needed them most.

Mr. Chairman, I thank you for this hearing and hope that we move quickly toward fully acknowledging the service and sacrifice our veterans have given this country. I thank the panelists for joining us today, and I look forward to your testimony.

STATEMENT OF THE HONORABLE R. JAMES "JIM" NICHOLSON**SECRETARY OF VETERANS AFFAIRS****FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS****February 16, 2005**

Mr. Chairman and members of the Committee, good morning. I am deeply honored that the President has given me the opportunity to serve as Secretary of Veterans Affairs. My service in the United States Army was the defining experience of my life and instilled me with a strong sense of duty, honor, and country. I look forward to working with you and the thousands of dedicated employees who are carrying out the compelling mission of the Department of Veterans Affairs (VA) by ensuring the delivery of timely, high-quality benefits and services earned by our servicemen and women who have sacrificed so much in defense of freedom.

I am pleased to be here today to present the President's 2006 budget proposal for VA. The request totals \$70.8 billion—\$37.4 billion for entitlement programs and \$33.4 billion for discretionary programs. Our budget request for discretionary funds represents an increase of \$880 million, or 2.7 percent, over the enacted level for 2005.

With the resources requested for VA in the 2006 budget, we aim to build upon many of the Department's achievements that have dramatically improved benefits and services to veterans and their families since the President came to office. The most noteworthy accomplishments are that VA:

- provided health care to about 1 million more patients
- improved the quality of patient care that sets the national standard of excellence for the health care industry
- dramatically lowered the backlog of rating claims for disability compensation and pension from a high of 432,000 to 321,000 (for all claims the backlog peaked at over 600,000)
- reduced the average length of time to process compensation and pension claims from a high of 230 days to approximately 160 days
- continued the largest expansion of the national cemetery system since the Civil War to honor veterans with a final resting place and lasting memorial that commemorates their service to our country.

With strong support from the President, VA has made excellent progress in sharpening its focus on more effectively meeting the needs of those veterans who count on us the most—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs. I fully support

this strategy and am committed to ensuring that our health care resources continue to be concentrated on care for veterans most in need of the Department's services. As an integral part of this focused strategy, we will make it a top priority to provide ongoing benefits and services to the servicemen and women who served in Operations Enduring and Iraqi Freedom. VA's goal is to ensure that every seriously injured or ill serviceman or woman returning from combat receives priority treatment and consideration. We will continue to work closely with the Department of Defense (DoD) to develop ways by which to move records more efficiently between the two agencies, share critical medical information electronically, protect the health of troops stationed in areas where environmental hazards pose threats, process benefit claims as one shared system, and in every way possible, ease their transition from active duty to civilian life.

Medical Care

The President's 2006 request includes total budgetary resources of \$30.7 billion (including \$750 million for construction and \$2.6 billion in collections) for the medical care program, an increase of 2.5 percent over the enacted level for 2005, and more than 47 percent above the 2001 level. The \$750 million in construction will be devoted to the Capital Asset Realignment for Enhanced Services (CARES) program, bringing the total Department investment to \$2.15 billion over 3 years.

Given the current fiscal environment, it is more important than ever that VA concentrate its resources, policies, and strategies on those veterans identified by Congress as high priority. The President's 2006 budget request includes policies and strategies used successfully during the last few years to focus VA health care resources on veterans with service-connected disabilities, those with lower incomes, and veterans needing our specialized services. In particular, this budget assumes continued suspension of enrollment of new Priority 8 veterans, as this has proven to be the most effective vehicle through which to focus our health care resources on our highest priority patients.

But maintaining the current enrollment policy will not in itself ensure us sufficient resources for the care of those who need us the most. The President's 2006 budget asks that you enact two important legislative proposals—an annual enrollment fee of \$250 and an increase in pharmacy co-payments from \$7 to \$15 for a 30-day supply of drugs, both pertaining to only Priority 7 and 8 veterans. This fee and the increase in co-payments pertain to only veterans who have no compensable service-connected disabilities and do have the means to contribute to the cost of their care. This budget asks these veterans to shoulder a small share of the cost so that we may adequately care for our high-priority veterans.

The proposed enrollment fee is very similar to the fee the law requires retired service members to pay in order to participate in TRICARE, and is arguably even more justified. As you know, TRICARE enrollees generally must have served on active duty for at least 20 years, and many of them are former enlisted personnel with modest retirement incomes. Many of the veterans who would be asked to pay our proposed fee would have served only 2 to 4 years. In addition, all Priority 7 and 8 veterans affected by this proposal would have incomes above \$25,842 if they are single and above \$30,013 if married.

I recognize that Congress has not supported either of these proposals during the past 2 years. However, these two legislative proposals are consistent with the priority health care structure Congress enacted several years ago and will help us meet the needs of our highest priority veterans. In addition, past utilization of VA's health care services has demonstrated that veterans with higher incomes (Priority 7 and 8 veterans) rely less on VA for delivering their health care and usually have other health care options, including third party insurance coverage and Medicare. An annual enrollment fee of \$250 and an increase in co-payments for pharmacy benefits from \$7 to \$15 would give higher income, non-disabled Priority 7 and 8 veterans the option of sharing a small portion of the cost of their care or utilizing other health care options. Our high-priority patients typically do not have other health care options, so we must act decisively to protect their interests by making sure that sufficient resources are available to handle their health care needs.

With medical care resources of \$30.7 billion, we project that we will treat more than 5.2 million patients. Those in Priorities 1 to 6 will comprise 78 percent of the total number of veteran patients in 2006. This will represent the third consecutive year during which our high-priority veterans will increase as a percentage of all veterans treated. In addition, about 9 of every 10 medical care dollars in 2006 will be devoted to meeting the health care needs of those veterans who count on us the most.

Even with an increasing patient workload among our highest priority veterans, we will continue our steadfast commitment to providing high-quality and accessible health care that sets the national standard of excellence for the health care industry. Our two primary measures of health care quality—clinical practice guidelines index and prevention index—focus on the degree to which VA follows nationally recognized guidelines and standards of care that the medical literature has proven to be directly linked with improved health outcomes for patients and more efficient care. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to hold steady at the current high performance level of 77 percent. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index is projected to remain at its existing high rate of performance of 88 percent. VA continues to exceed the performance of private

sector and Medicare providers for all 15 key health care quality indicators for which comparable data are available. These indicators include cancer screening for early detection, and immunization for influenza and pneumonia. In addition, they cover disease management measures such as compliance with accepted clinical guidelines in managing diabetes, heart disease, hypertensive disease, and mental health.

The Department has greatly improved access to our health care services during the last few years by opening additional outpatient clinics, applying information technology strategies to streamline administrative, business, and care delivery processes, and implementing pay policies and human resource management practices to facilitate hiring and retain sufficient health care workers to meet capacity demands across the full continuum of care. These initiatives have helped VA raise the percent of primary care appointments scheduled within 30 days of the patient's desired date to 94 percent and the percent of specialty care appointments scheduled within 30 days of the patient's desired date to 93 percent. By continuing these types of strategies, improving clinical efficiencies, and effectively utilizing the resources requested in our 2006 budget, VA will maintain these high performance levels.

The Department's record of success in health care delivery is substantiated by the results of the 2004 American Customer Satisfaction Index (ACSI). Conducted by the National Quality Research Center at the University of Michigan Business School, the most recent ACSI survey found that customer satisfaction with VA's health care system was markedly above the satisfaction level for Federal Government services as a whole. Results released in December 2004 revealed that inpatients at VA medical centers recorded a satisfaction level of 84 out of a possible 100 points, while outpatients at VA clinics registered a satisfaction score of 83. Both of these are well above the government average of 72.

In addition, the results of a recent study conducted by the RAND Corporation revealed that patients in VA's health care system were more likely to receive recommended care than private-sector patients. Quality of care was better for VA patients on all measures except acute care, for which care was similar for both patient groups. RAND researchers examined the medical records of nearly 600 VA patients and about 1,000 non-VA patients with similar health problems. They compared the treatment received by both groups to well-established standards for medical care for 26 conditions. They found that 67 percent of VA patients received care that met the latest standards of the health care profession compared with 51 percent of non-VA patients. For preventive care, such as vaccination, cancer screening, and early disease detection and treatment, 64 percent of VA patients received the appropriate care compared to only 44 percent in the private sector. The RAND researchers attributed the difference in patient care to technological innovations, such as VA's computerized patient records, and to performance measurement policies holding top managers

accountable for standards in preventive care and the treatment of long-term conditions.

As another means by which to ensure sufficient resources are available to address the health care needs of those veterans who count on us the most, VA is proposing to revise the eligibility criteria for long-term care services to focus on the following groups of veterans:

- those injured or disabled while on active duty, including veterans who served in Operations Enduring and Iraqi Freedom
- those catastrophically disabled
- patients requiring short-term care subsequent to a hospital stay
- those needing hospice or respite care.

These eligibility criteria would be applied to VA-sponsored long-term care services, including VA, community, and state nursing homes. This long-term care strategy will save approximately \$496 million that will be redirected toward meeting the health care needs of veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

In 2006 the Department will continue to expand access to non-institutional long-term care services to all enrolled veterans with an emphasis on community-based and in-home care. In many cases this approach allows VA to provide these services to veterans where they live and to care for them in the comfort and familiar setting of their home surrounded by their family. During 2006 VA will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 35,500. This total is over 50 percent above the number of patients receiving this type of care in 2001. Funding for non-institutional long-term care in 2006 will be about 67 percent higher than the resource level devoted to this type of health care service in 2001.

VA's 2006 medical care request includes \$1.2 billion (an additional \$100 million over the 2005 enacted level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. VA is already providing prosthetics and sensory aids to many military personnel who served in Operations Enduring and Iraqi Freedom and will continue to provide them as needed.

The President's 2006 budget includes \$2.2 billion (an additional \$100 million over the 2005 level) to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the nation to a full continuum of care for veterans with mental health disorders.

We have included a management efficiency rate of 2 percent which will yield about \$600 million in 2006. We continue to monitor and emphasize the need for performance that results in minimizing unit costs where possible, and eliminating inefficiency in the provision of quality health care. To that end, we have included

within this savings target, \$150 million that will be achieved through implementation of improved contracting practices with medical schools and other VA affiliates for scarce medical specialties. This is a long-standing issue for which the Department is aggressively implementing management changes to ensure fair pricing for the services provided by our affiliates.

As a result of continual improvements in our medical collections processes and the policy changes presented in this budget request, we expect to collect about \$2.6 billion in 2006 that will substantially supplement the resources available from appropriated sources. This figure is \$635 million (or 32.5 percent) above the 2005 estimate, with two-thirds of the increase due to the two important legislative proposals, and is more than 48 percent higher than the 2004 collections total. VA has an expanded revenue improvement strategy that focuses on modeling industry best performance by establishing industry-based performance and operational metrics, developing technological enhancements, and integrating industry-proven businesses approaches, including the establishment of centralized revenue operation centers. There are two electronic data initiatives underway that will add efficiencies to the billing and collections processes. The electronic and insurance identification and verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in this electronic data exchange. We are pursuing enhancements which will provide additional insurance information stored by other government agencies. Our second initiative will result in electronic outpatient pharmacy claims processing to provide real-time claims adjudication.

Capital Asset Realignment for Enhanced Services (CARES)

The President's budget request includes \$750 million in 2006 to continue the CARES program that will renovate and modernize VA's health care infrastructure and provide greater access to higher quality care for more veterans, closer to where they live. About \$50 million of this total relates to the sale of assets and enhanced use proceeds of the Lakeside hospital in Chicago. The budget request provides a 3-year (2004-2006) investment total of \$2.15 billion committed to this historic transformation of our health care system. These resources will be used to address our prioritized list of major capital investments. The proposed projects for 2006 will advance the CARES program by providing construction funding for five projects for which design work has already started, as well as two additional projects to be initiated in 2006. All of these capital projects support the recommendations included in the CARES Decision report. About half of the CARES funding requested for 2006 will be devoted to three major construction projects:

- Las Vegas, Nevada, New Medical Facility—\$199 million to complete phase two construction, providing up to 90 inpatient beds, a 120-bed nursing home care unit, ambulatory care center, and administrative and support functions, all of which will expand capacity and increase the scope

of health care services available; VA is working with DoD to ensure mutual needs are met

- Cleveland, Ohio, Cleveland-Brecksville Consolidation—\$87.3 million to complete phase two construction; this project will consolidate and co-locate all clinical and administrative functions of a two-division medical center at the Wade Park VA Medical Center, leading to annual cost savings of more than \$23 million and enhancing the quality of care
- Pittsburgh, Pennsylvania, Consolidation of Campuses—\$82.5 million to complete phase two construction; this project will consolidate a three-division health care delivery system into two divisions which will improve patient care by providing a state-of-the-art health care environment and reducing operating expenses.

Our capital investment planning process and methodology involve a Department-wide approach for the use of capital funds and ensure all major investments are based upon sound economic principles and are fully linked to strategic planning, budget, and performance measures and targets. All CARES projects have been reviewed using a consistent set of evaluation criteria that address service delivery enhancements, safeguarding assets, support of special emphasis programs and services, capital portfolio goals, alignment with the President's Management Agenda, and financial priorities.

Medical and Prosthetic Research

The President's 2006 budget includes \$786 million to support VA's medical and prosthetic research program. This resource level will fund nearly 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of aging, acute and traumatic injury, the effects of military and environmental exposures, mental illness, substance abuse, cancer, and heart disease.

The requested level of funding for the medical and prosthetic research program will position the Department to build upon its long track record of success in conducting research projects that lead to clinically useful interventions that improve veterans' health and quality of life. Examples of some of the recent contributions made by VA research to the advancement of medicine are:

- development of an artificial nerve system that enables a patient with upper-limb paralysis to grasp objects
- creation of a new collaborative model for treating depression in older adults, the application of which potentially saves lives, reduces patients' level of pain, and improves their overall functioning
- the finding that proper intake of cereal fiber and vitamin D are among the best ways to prevent serious colon polyps that may lead to colorectal cancer
- development of an oral drug that halts the deadly action of the smallpox virus.

In addition to VA appropriations, VA researchers compete and receive funds from other federal and non-federal sources. Funding from external sources is expected to continue to increase in 2006. Through a combination of VA resources and funds from outside sources, the total research budget in 2006 will be nearly \$1.7 billion.

Veterans' Benefits

The Department's 2006 budget request includes \$37.4 billion for the entitlement costs associated with all benefits administered by the Veterans Benefits Administration (VBA). This total includes an additional \$812 million for disability compensation payments to veterans and their survivors for disabilities or diseases incurred or aggravated while on active duty. Recipients of these compensation benefits are projected to increase to 3 million in 2006 (2.7 million veterans and 0.3 million survivors, or 400,000 more than when the President came to office).

The President's budget request includes \$1.26 billion for the management of the following benefits programs—disability compensation; pension; education; vocational rehabilitation and employment; housing; and life insurance. This total is \$77 million, or 6.6 percent, over the 2005 level. As a result of the enactment of the Consolidated Appropriations Act, 2005 (Public Law 108-447), an additional \$125 million will be made available to VBA (through a transfer of funds from medical care) for disability benefits claims processing. Of this total, \$75 million will be used during 2005 and the remaining \$50 million will be used in 2006. The overwhelming majority of these funds will be used to address the increased volume of compensation claims from both separating service members and older veterans who had not previously submitted claims.

As a Presidential initiative, improving the timeliness and accuracy of claims processing remains the Department's top priority associated with our benefits programs. Last year the timeliness of our compensation and pension claims processing improved by 9 percent (from 182 days in 2003 to 166 days in 2004). While we were successful in reducing the time it takes to process claims for compensation and pension benefits, we were not able to improve timeliness as much as we had projected at the beginning of the year. Entering 2004, VA was well positioned to meet our performance goals pertaining to the timeliness of processing claims. However, a September 2003 decision by the Federal Circuit Court in the case of the *Paralyzed Veterans of America et. al. v. the Secretary of Veterans Affairs* required VA to keep veterans' claims open for 1 year before making a decision to deny a claim. As a result, decisions on over 62,000 claims were deferred, many for as much as 90 days. While the President signed correcting legislation in December 2003, the impact of the court decision in the early portion of 2004 was substantial, as the number of pending claims had grown dramatically. VA made significant progress during the last half of the year,

but we were not able to fully overcome the negative effects from this court decision on our claims processing timeliness.

We have had to revise our claims processing timeliness goals for the next 2 years due, in part, to the lingering effect of the Federal Circuit Court decision. Also having an impact on the timeliness of processing is the increasing volume of disability claims. In addition, VA will continue to face the retirement of staff members highly experienced in processing claims. While we have established a sound succession plan, the new employees we are hiring will require both extensive training and substantial claims processing experience in order for them to reach the productivity level of those leaving the Department.

During 2005 we expect to reduce the average number of days to process compensation and pension claims to 145 days, an improvement of 12.7 percent from the 2004 performance level. With the resources requested in the 2006 budget, we will be able to maintain this improved timeliness in support of this Presidential initiative. In addition, we will reduce the number of pending claims for compensation and pension benefits to 283,000 by the end of 2006, a reduction of 12 percent from the total at the close of 2004.

We will increase our efforts to ensure the consistency of our disability evaluations from one regional office to another. VA has made significant improvements in both the accuracy and consistency of its benefit entitlement decisions due to increased quality assurance efforts and more focused training of claims adjudicators. However, more must be done to ensure the Department meets its commitment to treating every veteran's claim fairly and equitably. A system-wide review of the rating program for disability compensation is underway. In addition, our efforts are supported in the 2006 budget by a request for \$1.2 million for skills certification testing and \$2.6 million for continued development of computer-based training tools. These initiatives will complement other ongoing efforts supported by our budget that address the issue of consistency and accuracy. Among these are:

- revision of all of the regulations that govern the compensation and pension programs in plain language to ensure that the rules can be applied consistently and fairly
- in-depth data analysis of benefit decisions to identify potential areas of inconsistency, increasingly possible with our new information technology applications and tools
- centralized processing of appeals remanded by the Board of Veterans' Appeals, and ongoing quality reviews of appealed claims decisions.

An important and successful component of VA's vision for providing a seamless transition for service members separating from active duty is the Benefits Delivery at Discharge (BDD) program. The BDD program enables active duty service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or

closely following, their military separation dates. Transitioning service members benefit greatly from the BDD program, which has been a vital part of the Department's strategy for improving timeliness and accuracy of disability compensation claims processing.

We believe the BDD program provides opportunities to not only benefit transitioning service members through timely and accurate claims processing, but also to bring new processing improvements and efficiencies to the system through consolidation of claims evaluation activities. An initiative is currently underway to consolidate disability compensation rating and authorization actions on all BDD claims to two sites nationwide. VA staff will continue work with transitioning service members at military bases to establish claims and arrange for timely medical exams, thereby retaining these successful aspects of the BDD program.

In support of the education program, the 2006 budget proposes \$7.8 million for continued development and implementation of the Education Expert System. The requested funds will be used to first transition education processing to VBA's corporate environment, followed by the development and deployment of a processing system that receives application and enrollment information electronically and processes that information in the new corporate environment without human intervention. While it will be a number of years before this system is fully deployed, it will ultimately lead to substantial improvements in education claims processing timeliness.

In April 2004 the Department's Vocational Rehabilitation and Employment Task Force released its report containing more than 100 recommendations on how to improve service to disabled veterans. The focus of the report was on development and implementation of a new, integrated service delivery system based on an employment-driven process. In response to the task force's recommendations, VA is including \$4.4 million in the 2006 resource request to be used for establishing a job resource lab in each regional office. These labs will include all of the necessary equipment, supplies, and resource materials to aid VA staff and veterans in conducting comprehensive analyses of local and national job outlooks, developing job search plans, preparing for interviews, developing resumes, and conducting thorough job searches. These self-service job resource labs will assist veterans in acquiring suitable employment through the use of a comprehensive on-line employment preparation and job-seeking tool.

In order to make the delivery of VA benefits and services more convenient for veterans and more efficient for the Department, we are requesting \$4.4 million for the collocation and relocation of some regional offices. This effort may involve collocations using enhanced-use authority, which entails an agreement with a private developer to construct a facility on Department-owned grounds and then

leasing all or part of it back to VA. At the end of these long-term lease agreements, the land and all improvements revert to VA ownership.

Burial

The President's 2006 budget includes \$290 million in discretionary funding for VA's burial program, which includes operating and maintenance expenses for the National Cemetery Administration, capital programs, the administration of mandatory burial benefits, and the State Cemetery Grants program. This total is nearly \$17 million, or 6.4 percent, over the 2005 enacted level.

The 2006 request includes \$167 million in administrative funding for VA's burial program, an increase of \$7.3 million (or 4.6 percent) from the 2005 enacted level. Within this total, \$156 million is for the operations and maintenance of VA's national cemeteries and \$11 million is for the administrative processing of claims for burial benefits. The additional funding will be used to meet the growing workload at existing cemeteries, primarily by increasing staffing and contract maintenance.

Our budget request for the burial program includes \$90 million for construction projects. Of this total, \$65 million is for major projects and \$25 million is for minor projects. Consistent with the provisions of the National Cemetery Expansion Act of 2003, we are requesting \$41 million in major construction funding for land acquisition for six new national cemeteries in the areas of Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota, Florida; and southeastern Pennsylvania. The 2006 request also includes funding to develop an annex for the expansion of Fort Rosecrans National Cemetery in Miramar, California. In addition, this budget provides \$32 million for the State Cemetery Grants program.

Our resource investments in the burial program produce positive results in service delivery to veterans and their families. We will expand access by increasing the percent of veterans served by a burial option within 75 miles of their residence to 82.2 percent in 2006, which is 6.9 percentage points above the 2004 figure. While our 2004 performance was extremely high in several key areas, we will continue to improve our performance in 2006 by increasing the percent of:

- survey respondents who rate the quality of service provided by the national cemeteries as excellent from 94 percent to 96 percent
- survey respondents who rate national cemetery appearance as excellent from 98 percent to 99 percent
- graves in national cemeteries marked within 60 days of interment from 87 percent to 89 percent.

These performance improvements will further enhance the outstanding reputation of VA's National Cemetery Administration which, in 2004, earned the

highest rating ever achieved by a public or private organization in the American Customer Satisfaction Index (ACSI). These results showed that the Department's national cemeteries produced a customer satisfaction rating of 95 out of a possible 100 points. This is two points higher than the last survey conducted in 2001 when VA's national cemeteries also ranked number one among federal agencies in customer satisfaction.

Management Improvements

VA continues to aggressively pursue a variety of initiatives aimed at ensuring we apply sound business principles to all of the Department's operations. Two of our most successful management improvement efforts during the last year focus on the strategic management of human capital and capital asset management.

As an integral component of our succession planning activities, we released a state-of-the-art "VA Recruitment" CD-ROM in September 2004 promoting the Department as an employer of choice. We distributed this to colleges and universities, military transition centers, veterans organizations, and VA vocational rehabilitation centers, offices, and medical centers. This initiative creates a corporate recruitment marketing approach that will give VA a competitive edge in attracting highly-qualified career applicants. The CD-ROM uses graphics and video streaming to present a wide spectrum of career opportunities and describes VA's goals and services, occupations, and the benefits of working for the Department. We will continue to focus on creative marketing initiatives and outreach to prospective applicants.

VA has also launched a Capital Asset Management System (CAMS) which is an integrated, Department-wide system that enables us to establish, analyze, monitor, and manage our portfolio of diverse capital assets through their entire lifecycle from formulation through disposal. CAMS provides a strategic view of existing, in-process, and proposed asset investments across all VA program offices and capital asset types. All offices now use this shared system to collect and monitor real property and capital asset information. In addition, VA has been approached by numerous agencies, including the Departments of Defense, Homeland Security, Commerce, and Interior to explore the replication of CAMS in their organizations.

VA's progress in this area places it in the forefront of other federal agencies in terms of its ability to meet the real property performance measures and guidelines that were recently finalized by the newly created Federal Real Property Council.

We are currently in the process of fully evaluating all of the information gathered during the operational tests of the Core Financial and Logistics System (CoreFLS) conducted last year. This year we will complete a comprehensive analysis of the product and any existing configuration gaps, examine lessons

learned from the pilot tests, and reevaluate our business processes. This will provide us with the information needed to refine the system as well as develop improved change management, training, and implementation procedures that are critical to successful deployment. In anticipation of an enhanced financial management system moving forward to full deployment at VA facilities nationwide, the Department's 2006 budget includes \$70.1 million for this project.

In support of one of the primary electronic government initiatives for improving internal efficiencies and effectiveness, the Department's 2006 budget provides \$8 million to continue the migration of VA's payroll services to the Defense Finance and Accounting Service (DFAS). This initiative will consolidate 26 federal payroll systems down to 2 federal payroll provider partnerships. VA is working with DFAS on all required tasks to ensure successful migration.

Closing

Mr. Chairman, our 2006 budget request of \$70.8 billion will provide the resources necessary for VA to:

- provide timely, high-quality health care to more than 5.2 million patients; 78 percent of all veteran patients will be veterans with service-connected disabilities, those with lower incomes, or veterans with special health care needs
- maintain the 2005 performance level of 145 days, on average, to process compensation and pension claims
- increase access to our burial program by ensuring that more than 82 percent of veterans will be served by a burial option within 75 miles of their residence.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

STATEMENT OF
RICHARD B. FULLER
NATIONAL LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE INDEPENDENT BUDGET
AND THE DEPARTMENT OF VETERANS' AFFAIRS BUDGET
FOR FISCAL YEAR 2006

FEBRUARY 16, 2005

Mr. Chairman and members of the Committee, as one of the four veterans services organizations publishing *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for FY 2006.

This is the 19th year, PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars have presented *The Independent Budget*, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 26 veterans service organizations, and medical and health care advocacy groups.

This FY 2006 budget request for health care is a shocking one, providing once again a woefully inadequate funding level for sick and disabled veterans. The Administration request of \$27.8 billion amounts to an increase of \$111 million in appropriated dollars – less than one-half of one percent over the amount provided in FY 2005. Last year's

request was the smallest health care appropriation request in nearly a decade. This year's request is even lower. Health care is not a luxury, but this budget request treats it like it is. Keep in mind that the VA itself has testified in the past that it requires a "13 or 14 percent per year increase in the money available to take care of just our core population of veterans." (Department of Veterans Affairs Health Care System: Hearing Before the House Committee on Veterans' Affairs, 108th Congress, January 29, 2003).

In place of dollars we are presented with a budget that relies far too heavily on gimmicks, accounting tricks, and on forcing some veterans to pay for the health care of other veterans. Shifting costs onto the back of other veterans is not the way to fulfill this nation's responsibilities to veterans. Once again, the Administration has proposed a \$250 annual enrollment fee, and increased pharmaceutical co-payments, ideas soundly rejected in the past by Congress. The budget also estimates that the VA will find \$590 million in management efficiencies, requiring major cutbacks in personnel and services at VA hospitals across the country. Last year, VA estimated "savings" of \$340 million. Absent a detailed list or plan to achieve these savings, we can only assume that these are only included to mask the true extent of the funding chasm faced by the VA in the upcoming fiscal year.

Punitive co-payments, enrollment fees, and other charges are designed not so much to raise revenues as they are meant to deter veterans from seeking their care at VA medical facilities. The VA estimates that its enrollment fee and co-payment proposals will cause more than 213,000 veterans to disenroll. In fact, if this budget submission is enacted, the VA expects enrollment to drop by nearly one-million veterans, a decrease of 12 percent, during FY 2006. This is not a lean budget, rather, it is a budget designed to strangle a health care system relied upon by sick and disabled veterans.

The Independent Budget is adamantly opposed to increasing co-payments. Veterans should not be forced to pay for the health care of their fellow veterans. Although Congress has given the Secretary of Veterans Affairs the authority to set and raise fees,

what was once thought of as only an administrative function has now become, in times of tight budgets, an expedient way to find the dollars needed to fund health care for veterans. Providing health care to veterans is a federal responsibility, and we look to Congress to provide the necessary resources to provide this care.

If this budget tells veterans that they better not get sick, what is it telling to veterans in need of long-term care? Although the true extent of the VA's cuts to long-term care may be difficult to fully discern, it is clear that this budget would gut long-term care, and violate the VA's statutory responsibility to maintain the capacity to provide long-term care.

The VA has proposed zeroing out grants for the construction of state extended care facilities, while slashing the per diem grants it provides state homes by \$229 million, a loss of revenue that could very well lead to closures in certain circumstances. The VA estimates that close to 30,000 fewer veterans will be treated under its proposals. The VA proposes \$124 million in cuts by "revising" eligibility criteria for long-term care. In the VA's budget submission in a chart summarizing obligations by activity, nursing home care is shown as being cut by \$351 million, and it is estimated that the VA's proposed budget would eliminate 5,000 nursing home beds. These cuts would have a drastic effect on some of our neediest veterans.

It is clear that the Administration's budget does not begin to meet the health care needs of veterans, nor does it reflect the resources needed by the VA to provide this care. We believe that *The Independent Budget* provides a conservative estimate that more accurately represents the needs of the VA.

For FY 2006, we are recommending a total appropriation for medical care of \$31.2 billion, an increase of \$3.5 billion. This reflects an increase of close to 13 percent. This estimate does not include funds attributed to MCCF, which we believe should be used to

augment a sufficient appropriated level of funding and not used to replace appropriated dollars.

The VA health care system, in order to fully meet all of its demands and to ameliorate the effects of chronic under-funding, could use many more dollars. *The Independent Budget* recommendation provides for the impact of inflation on the provision of health care, and mandated salary increases of health care personnel. It would provide the resources to begin to meet the demands of specialized services and programs, as well as the ever-increasing influx of new veterans entering the system. It is estimated that of the more than 168,000 Iraq veterans who are no longer on active duty, sixteen percent have sought VA health care. The full impact of the two-year grant of priority health care for these veterans is yet to be fully felt. We also believe that *The Independent Budget* recommendation, if enacted, would allow the VA to begin enrolling Category 8 veterans once again.

For Medical and Prosthetic Research, *The Independent Budget* is recommending \$460 million. This represents a \$58 million increase over the FY 2005 amount. The Administration has proposed a \$9 million cut. Research is a vital part of veterans' health care, and an essential mission for our national health care system.

In closing, the VA health care system faces two chronic problems. The first is a budget submission that ignores the costs of providing care while advocating draconian health care rationing. The second is a lack of consistent funding. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them. Far too often veterans'

funding is the subject of an omnibus bill that is enacted months after the start of the fiscal year.

Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive.

The only solution we can see is for this Committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it. We look forward to working with this Committee in order to begin the process of moving a bill through the Senate, and the House, as soon as possible.

It is easy to forget, when dealing with dollars and budgets, that we are ultimately dealing with real people, people who will be affected personally by the cuts and so-called “savings” proposed by this Administration. We ask that you remember these men and women, these veterans who have sacrificed so much for us, when you are drawing up your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

This concludes my testimony. I will be happy to answer any questions you may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$228,000 (estimated).

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense -- \$1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$228,000 (estimated).

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$228,803.

**STATEMENT OF
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
of the
DISABLED AMERICAN VETERANS
before the
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 16, 2005**

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I come before you today to present the views of the Disabled American Veterans (DAV) and its Auxiliary on the President's fiscal year (FY) 2006 budget for veterans' programs. In addition to our assessment of the President's budget recommendations, I will also provide the Committee with our own budget and program recommendations as contained in *The Independent Budget* (IB). The IB is a budget and policy document that sets forth the collective views of the DAV, AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW).

The President's FY 2006 budget requests \$70.8 billion in budget authority for the Department of Veterans Affairs (VA). This total consists of \$37.4 billion for mandatory spending in the benefit programs and \$33.4 billion for discretionary funding. The mandatory funding includes \$478.3 million to cover the 2.3% cost-of-living adjustment (COLA) the budget recommends for disability compensation. The discretionary funding includes \$30.7 billion for veterans' medical care, of which \$2.6 billion would be from projected copayments, enrollment fees, and other collections. The remaining \$2.7 billion in discretionary funding would cover general operating expenses, some construction costs, and medical research.

The President's budget seeks no improvements in the benefits programs other than an annual COLA for compensation. Based on a projected increase in the cost of living as measured by the Consumer Price Index, disability compensation, as well as dependency and indemnity compensation (DIC) and the annual clothing allowance, also included in the compensation account, would be increased 2.3%. Increases in monthly benefits for compensation and DIC would be effective December 1, 2005. As we observe in the IB, these benefits must be adjusted periodically to keep pace with inflation. Veterans whose earning power is limited or completely lost due to service-connected disabilities must rely on compensation for the necessities of life. Similarly, surviving spouses and dependent children of veterans who died of service-connected causes often have little or no income other than DIC. The rates are modest, and any erosion due to inflation has a direct detrimental impact on recipients with fixed incomes. We therefore recommend in the IB and support the Administration's recommendation that Congress enact legislation to increase the rates of these benefits.

In the IB, we also recommend that Congress reject any suggestion or move to permanently extend provisions that, for the next several years, require rounding down of compensation COLAs to the nearest whole dollar amount. Congress has historically increased

disability compensation and DIC rates each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the Federal budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break the habit of extending this round-down provision and has extended it even in times of budget surpluses. Inexplicably, VA budgets have recommended in previous years that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for 1 or 2 years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and dependents, who must rely on their modest compensation for basic needs.

In the IB, we make several other recommendations for legislation to improve the compensation program, and we take positions against certain detrimental proposals that have been offered or entertained in the past. We recommend adjustments in the grants for specially adapted housing and home adaptations provided to certain veterans with the more serious service-connected disabilities. Similarly, we recommend an increase in the grant for purchase of specially equipped automobiles provided to veterans with service-connected disabilities that require certain adaptations. Due to a lack of regular adjustments for inflation, these special benefits have lost much of their value. We recommend legislation to authorize use of modern mortality tables in setting premium rates for Service-Disabled Veterans' Insurance (SDVI). The intended benefit of offering life insurance to disabled veterans at standard rates is defeated by the continued use of 1941 mortality tables as a basis for premiums. We recommend that Congress increase the \$10,000 maximum to \$50,000 for SDVI policies to more meaningfully correspond to today's income replacement needs of survivors. We also recommend improvements for the education, vocational rehabilitation, and home loan programs. We ask the Committee to refer to the IB for these recommendations and give them full consideration.

The administrative expenses for the benefit programs are included in the discretionary funding for the VA's Veterans Benefits Administration (VBA), which together with funding for Departmental Administration, traditionally made up the General Operating Expenses (GOE) appropriation. Because Congress has resisted adopting the new budget account structure for VA employed in the President's budget beginning with FY 2004, we continue to observe in the IB the traditional account structure under GOE.

The level of funding sought in the President's budget would reduce VBA staffing again for the third consecutive year. In FY 2006, VBA would have 76 fewer fulltime employees (FTE) under the President's budget than it had in FY 2005, and 539 fewer than it had in FY 2003. Even this net reduction of 76 FTE does not present a true picture of the impact of the President's budget because it would cannibalize other benefit lines to partially alleviate critical staffing shortages in the Compensation and Pension (C&P) and Vocational Rehabilitation and Employment (VR&E) Services. Loan Guaranty Service would lose 205 FTE, Education Service would lose 14 FTE, and Insurance Service would lose 6 FTE.

According to the “Budget Highlights” in the President’s Budget Submission, one of VA’s highest priorities is to “[i]mprove the timeliness and accuracy of claims processing.” The Budget Submission states: “Funds are included in the Veterans Benefits Administration to sustain progress made under the Secretary’s priority of improving timeliness and accuracy of claims.” We assume the intent was to say that the funds requested are sufficient to continue the course of improving claims processing timeliness and accuracy. In another statement, the Budget Submission declares: “As a Presidential initiative, improving the timeliness and accuracy of claims processing remains the Department’s top priority associated with our benefit programs.” However, it appears that this budget abandons efforts to improve on the intolerable situation in which VA has large backlogs of pending claims and in which benefits awards to veterans are delayed as a consequence. The Budget Submission for FY 2004, for example, set a goal of reducing the average processing time for compensation and pension claims from a projected 165 days in FY 2003 to 100 days in FY 2004, with a strategic target of 90 days. The Budget Submission for FY 2005 set a goal of reducing the average processing time for compensation and pension claims from a projected 145 days in FY 2004 to 100 days in FY 2005, with a strategic target of 90 days. The FY 2006 Budget Submission revises these figures to show that average was actually 166 days in FY 2004, that the time will be reduced to 145 days in FY 2005, and that the goal for FY 2006 is also 145 days. The strategic target has been increased from 90 days to 125 days. This demonstrates that the resources requested are insufficient to meet a goal that VA portrays as a “top priority.” These figures call into question the genuineness of this stated goal.

The IB has recommended that C&P Service be authorized 8,929 FTE, the FY 2004 staffing level. In addition, C&P Service had 174 FTE for adjudication of burial benefit claims, making the FY 2004 total 9,103 FTE. The President’s budget requests 9,087 FTE for C&P. While this is an increase over the 8,959 FTE authorized for FY 2005, the failure to meet timeliness goals demonstrates that the President’s request for FY 2006 is insufficient. At a minimum, C&P Service should be authorized 9,103 FTE.

For Education Service, the IB recommended staffing of 770 direct program FTE, an increase of 33 FTE over the FY 2005 staffing level. As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. However, with the inability to hire new employees during FY 2004, Education Service timeliness in processing original and supplemental education claims declined during FY 2004. In addition, legislation authorizing a new education benefit for members of the National Guard and Reserve pressed into active service for 90 or more days will add to the existing workload during FY 2005 and future years, making it even more difficult to address the education caseload in a timely manner. In FY 2003, the average time to process original education claims was 23 days. The strategic target was 10 days. The Budget Submission estimates that the average time to complete original education claims in FY 2006 will have grown to 27 days. Without an increase in staffing adequate to meet the existing and added workload, service to veterans seeking educational benefits will continue to decline. The President’s budget would reduce direct program FTE from 737 in FY 2005 to 717 in FY 2006. The President requests 53 fewer FTE than the IB recommends. Based on experience with the average number of claims decisions a claims examiner can process and the average number of telephone and Internet contacts an

employee can handle, to meet its workload demands in a satisfactory fashion, VBA must increase direct program staffing in its Education Service in FY 2006 to 770 FTE.

For VR&E Service, the President's budget seeks funding for 963 direct program FTE. The IB recommends 1,017 direct program FTE for this business line. During FY 2005 and continuing into FY 2006, VR&E's workload is expected to increase primarily as a consequence of the war in Iraq and ongoing hostilities in Afghanistan. Also, given its increased reliance on contract services, VR&E needs approximately 60 additional FTE dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA Vocational Rehabilitation and Employment Task Force recommended in its March 2004 report the creation of new staff positions and training for this purpose. Other new initiatives recommended by the Task Force also require an investment of personnel resources. To meet its increasing workload and implement reforms to improve the effectiveness and efficiency of its programs, it is projected that VR&E will need a minimum of 1,017 direct program FTE in FY 2006, 54 more than the President requested.

The IB recommends funding for continued development and deployment of modern information technology (IT). The President's budget appears to have abandoned many of VA's IT initiatives. We recommend that Congress provide \$4 million for predeployment testing of new IT applications at VA's Hines Information Technology Center. Automated testing of new IT at the Hines test center avoids diverting field office staff from their regular duties to test the new applications and avoids the pitfalls of deploying untested software to VA field offices. We recommend \$1 million for training to keep VA's IT staff abreast of changes in IT systems.

For new subsystems in C&P Service to be integrated into VETSNET, we recommend that Congress provide \$12 million. To continue document preparation and scanning at VA's pension maintenance centers and to continue evaluating VA's electronic imaging system, "Virtual VA," for eventual nationwide deployment, we recommend an appropriation of \$2 million in FY 2006.

We recommend that Congress provide \$2 million to cover the costs of necessary enhancements of Education Service's Imaging Management System (TIMS). TIMS is Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. VA needs to consolidate four separate TIMS databases into one database accessible by the Internet and add capacity to meet increased workload demands. This will make the system fully interactive nationwide and will include the critical additional capacity necessary for continued viability of the system.

To allow for more efficient award processing and sharing of information with contractors, employment services, and outside partnership entities by deploying a Web-based version of VR&E's case management system, WINRS, we recommend that Congress provide \$3 million. To allow it to receive enrollment information from schools and to enable it to have online contact between veterans and case managers, we recommend that VR&E be provided \$2 million for its "Internet Application" initiative.

We recommend a \$2 million appropriation for upgrading and expansion of the “Loan Servicing System” to allow claimants direct access to Loan Guaranty Service’s Automated Certificate of Eligibility application. As we noted, the President’s budget would reduce staffing in Loan Guaranty Service by 205 FTE in FY 2006. An annotation to budget briefing documents provided to congressional staff and veterans organizations states: “FTE decreases are offset by productivity improvements such as information technology, training, management efficiencies, etc.” Yet the President’s budget provides no money to allow claimants access to an Automated Certificate of Eligibility, an initiative that would be consistent with some reduction of FTE. Experience would suggest that management efficiencies can only be quantified accurately and can only be counted on to increase productivity after they have been attained. It appears that when requested resources fall short of what is necessary to meet workload demands, VA simply declares that it can achieve management efficiencies in the amount of savings necessary to fill the obvious gap between resources needed and appropriations requested. In short, the amount of savings projected appears to correspond to the funding shortfall rather than being derived from any actual calculation based reasonably on expected new efficiencies.

In connection with the funding request for medical care, the President’s budget assumes savings of \$590 million in management efficiencies. Again, we believe such a convenient assumption is unjustified. As another means to bridge the gap between the resources requested and the resources necessary, the budget would shift the shortfall onto veterans themselves. It would impose a \$250 annual enrollment fee for “all” Priority 7 and 8 veterans. It would increase pharmacy copayments to 214% of the current amount, from \$7 to \$15. A veteran would be required to pay this copayment on each of his or her prescriptions for a 30-day supply of medications. Such user fees are nothing more than a disguised tax upon veterans’ benefits. In addition, the budget would continue the suspension of enrollment of new Priority 8 veterans.

These initiatives would accommodate lower appropriations by bringing revenues from collections into the system, by driving large numbers of veterans away from VA, and by preventing any growth in patient load from priority 8 veterans. VA projects that the enrollment fee and higher copayments will increase collections by \$424 million and repulse 213,000 veterans from the VA medical care system. Assuming all of these changes, the FY 2006 budget would provide for the Veterans Health Administration only a 2.41% increase over FY 2005 budget authority in constant, or nominal, dollars. Appropriated dollars would account for only 0.4% of this increase. According data in the Budget Submission, VA experienced a 4.1% growth rate in patients treated in FY 2004, and VA projects a 7% growth of enrollees between fiscal years 2004 and 2006. The Budget Submission for VA states that it includes policy changes to “assure sufficient resources” are available to continue to provide care to all enrolled veterans.

We often hear Government officials repeating Lincoln’s words to communicate its solemn mission, “to care for him who shall have borne the battle . . .” Many veterans in Priority Groups 7 and 8 have borne the battle with the good fortune not to be wounded, and some have service-connected disabilities, but this budget does not care for them. It employs verbal extenuation to masquerade as an honorable and positive action its efforts to abandon these veterans and drive them from the system. The Budget Submission for VA states that the budget supports a continued focus on health care needs of VA’s “core group of veterans.” Unlike Lincoln’s positive words urging the nation to honor its moral obligation to veterans, this

statement of exclusion seeks to disavow the Nation's obligation for political expedience. A medical care system that treats only the sickest of the sick and the poorest of the poor is not sustainable and would be undesirable. Such restricted focus would in the end seriously erode the quality of care for today's and tomorrow's veterans.

Though we wanted to express our concerns about the glaring inadequacy and obvious bad policy of this budget for veterans' medical care, we will defer to our partners from PVA to present more specifically the IB's views and recommendation of mandatory funding for veterans' medical care. To avoid unnecessary duplication, we also defer to our IB colleagues from AMVETS and the VFW to cover the budget for the National Cemetery Administration and construction.

We should not forget veterans in times of peace following conflicts, but this is certainly a time that our national commitment to veterans should be at its highest, a time that providing adequately for them should be foremost in the minds of members and on the agenda of Congress. This budget does not provide adequately for veterans programs. We urge this Committee and Congress to correct its deficiencies and fulfill our commitment to veterans.

**DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS**

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received \$55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received \$8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's CONSTRUCTION BUDGET FOR FISCAL YEAR 2006

WASHINGTON, D.C.

FEBRUARY 16, 2005

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I would express our deep appreciation for being included in today's important legislative hearing to discuss the budget for the Department of Veterans Affairs (VA). As a constituent member of the Independent Budget for VA, the VFW is responsible for the Construction portion of the VA budget so I will limit today's testimony to that area.

The Department of Veterans Affairs (VA) construction budget includes major construction, minor construction, grants for construction of state extended-care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund. VA's construction budget annual appropriations for major and minor projects decreased sharply to an all-time low in FY 2003. Over the past several years, there has been political resistance to funding of any major projects before the Capital Assets Realignment for Enhanced Services (CARES) process was completed. The prospect of system-wide capital assets realignment through the CARES process continues to be used as an excuse to hold all construction projects hostage.

VA has recently completed another phase of CARES, which is a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through CARES, an ongoing process, VA is evaluating the demands for health-care services and identifying changes that will help meet veterans' current and future health-care needs. The CARES process included the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the supply and identification of current and future gaps in infrastructure capacity. This resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure.

Since the publication of the FY 2005 *Independent Budget*, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The Secretary of Veterans Affairs formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, the DNCP market plans included flawed projections for outpatient mental health services and questionable projections for inpatient mental health services. The plans did not include any projections for long-term care other than catastrophic care. Accordingly, the commission recognized the importance of mental health services and long-term care to the veteran population and acknowledged in the CARES Commission report that VA must make modifications to its projections to include mental health services and long-term care.

Also last year, during the initial stages of the CARES process, *The Independent Budget* veterans service organizations (IBVSOs) suggested that further data be obtained to support various CARES recommendations that would either close or change the mission of some VA facilities. We appreciate then Secretary Principi's efforts in establishing a CARES Implementation Board and the plan to begin further feasibility studies of the 22 VA facilities

identified for possible mission adjustments in the secretary's CARES decision document. However, as stakeholders, we would like to remind VA that it is imperative that veterans service organizations remain involved in all phases of this new CARES study, which will be divided into three different segments: a health-delivery study, a comprehensive capital plan, and an excess property plan identifying new land usage or disposal.

Mr. Chairman, we remain supportive of the CARES process as long as the primary emphasis is on the "ES" portion of the acronym. We understand that the locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the upkeep of inefficient buildings, and to accommodate modern methods of health-service delivery. Accordingly, we concur with VA's plan to proceed with the feasibility study of the remaining 22 facilities contained in the Secretary's decision document.

In light of the Administration's totally inadequate budget request for VA, the IBVSOs are very concerned that Congress may not adequately fund all CARES proposed changes when CARES implementation costs are factored into the appropriations process. This will only further exacerbate the current obstacles impeding veterans' timely access to quality health care. It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated for the construction of new facilities and renovations of existing hospitals, as deemed appropriate and pertinent.

The VFW and IBVSOs recommend that Congress appropriate, not including funding specific to CARES, \$563 million to the Major Construction account for FY 2006. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition and claims, as follows:

Construction, Major Projects Recommended Appropriation

FY 2006 Recommendation by type of service
Medical Program (VHA)

(Dollars in thousands)	
Seismic Improvements	\$315,000
Clinical Improvements	\$26,250
Patient Environment	\$10,500
Advance Planning Fund	\$63,000
Asbestos Abatement	\$63,000
National Cemetery Administration	\$85,050
Recommended FY 2006 Appropriation	\$562,800

The VFW and IBVSOs recommend that Congress appropriate \$716 million to the Minor Construction account for FY 2006. These funds contribute to construction projects costing less than \$7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, staff offices account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects:

Construction, Minor Projects Recommended Appropriation

FY 2006 Recommended by Type of Service
Medical Program (VHA)

(Dollars in thousands)	
Inpatient Care Support	\$136,000
Outpatient Care and Support	\$105,000
Infrastructure and Physical Plant	\$157,000
Research Infrastructure Upgrade	\$52,000
Historic Preservation Grant Program	\$21,000
Other	\$26,000
Architectural Master Plans Program	\$100,000
VBA Regional Office Program	\$36,000
National Cemetery Program	\$36,000
VA Research Facility Improvement and Renovation	\$47,000
IB Recommended FY 2006 Appropriation	\$716,000

It is here painfully evident just how inadequate the administration's VA construction request is as compared to the VFW/IB identified need:

	FY 2005	FY 2006 Admin	Difference Admin & 2005	FY 2006 IB	Difference IB & Admin
Construction Programs					
Construction, Major	455,130	607,100	151,970	562,800	-44,300
Construction, Minor	228,933	208,726	-20,207	720,000	511,274
Grants for State Extended Care Facilities	104,322	0	-104,322	150,000	150,000
Grants for Construction of State Vets cemeteries	31,744	32,000	256	37,000	5,000
Subtotal, Construction Programs	820,129	847,826	27,697	1,469,800	621,974

It is equally and most painfully clear that long-term care for veterans is to bear the brunt of the proposed cutbacks in the budget, including the elimination of federal spending on state-run homes that provide veterans with long-term care. The program, which dates back to the Civil War, received \$104 million this fiscal year. The White House plan would also trim nursing home care by \$351 million, which would eliminate approximately 5,000 beds in VA-run nursing homes. These cuts, at a time when demand for VA long-term care services is increasing on the rise with a rapidly aging veteran population, are unconscionable and absolutely reprehensible.

In another area, good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs—such as seismic correction, compliance with the Americans With Disabilities Act (ADA) and Joint Commission of Accreditation of Health Care Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES—VA's construction budget continues to be inadequate.

The Independent Budget for Fiscal Year 2005 cites the recommendations of the interim report of the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we again cite the recommendations of the PTF.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only \$246 million annually, a recapitalization rate of 0.64 percent of the \$38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the Department of Defense adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

Mr. Chairman, the PTF also recommended that "an important priority is to increase infrastructure funding for construction, maintenance, repair and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure."

The PTF goes on to state, "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus but instead submits an annual top 20-facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF articulates that VA must accomplish three key objectives:

- (1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health-care delivery;
- (2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and
- (3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

We of the IBVSOs concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Mr. Chairman and distinguished members of the Committee, Congress must ensure that there are adequate funds for the major and minor construction programs so the VHA can undertake all urgently needed projects.

I will here briefly articulate our view that in those instances where no impediment arises in providing veteran's care and services the extensive inventory of historic structures must be protected and preserved. VA's historic structures illustrate America's heritage of veterans' care, and they enhance our understanding of the lives of the soldiers and sailors who have shaped our country. Of the almost 2,000 historic structures VA owns, many are neglected and deteriorate further every year. These structures must be stabilized, protected, and preserved. As the first step in addressing this responsibility, VA must develop a comprehensive national program for its historic properties. Because most heritage structures are not suitable for modern patient care, the Capital Asset Realignment for Enhanced Services planning process did not produce a national preservation strategy. VA must undertake a separate initiative for this purpose immediately.

VA should inventory its historic structures, classify their current physical condition, and evaluate their potential for adaptive reuse by either the medical centers, local governments, nonprofit organizations, or private-sector businesses. To accomplish these objectives, we recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and also with private organizations, such as the National Trust for Historic Preservation. Such expertise should prove helpful in establishing this new program. VA must also expand its limited preservation staffing.

For its adaptive reuse program, VA needs to develop models and policies that will protect historic structures that are leased or sold. VA's legal responsibilities, for example, could be addressed through easements on property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully assisted the Department of the Army in managing its historic properties.

We recommend that specific funds should be included in the FY 2006 budget to develop a comprehensive program with detailed responsibilities for the preservation and protection of VA's inventory of historic properties.

The last issue I will address here today is the view that VA should avoid the temptation to reuse empty space inappropriately. Studies have suggested that the VA medical system has extensive empty space that can be cost-effectively reused for medical services, and that one medical center's unused space may help address another's deficiency. Although these space inventories are accurate, the basic assumption regarding viability of space reuse is not.

Medical design is complex because of the intricate relationships that are required between functional elements and the demanding requirements of equipment that must be accommodated. For the same reasons, medical facility space is rarely interchangeable. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a second-floor space deficiency because there is no functional adjacency. Medical space has very critical inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care. In order to preserve these relationships, departmental expansions or relocations usually trigger "domino" effects on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Medical space's permanent features, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading cannot be altered. Different medical functions have different requirements based on these characteristics. Laboratory or clinical space, for example, is not interchangeable with ward space because of the need for different column spacing and perimeter configuration. Patient wards require natural light and column grids that are compatible with room layouts. Laboratories should have long structural bays and function best without windows. In renovation, if the "shell" space is not suited to its purpose, plans will be larger, less efficient, and more expensive.

Using renovated space rather than new construction only yields marginal cost savings. Build out of a "gut" renovation for medical functions is approximately 85 percent of new construction cost. If the renovation plan is less efficient or the "domino" impact costs are greater, the savings are easily lost. Remodeling projects often cost more and produce a less satisfactory result. Renovations are appropriate to achieve critical functional adjacencies, but they are rarely economical.

Early VA centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most hospitals have been consolidated into large, tall "modern" structures. Over time, these central towers have become surrounded by radiating wings with corridors leading to secondary structures. Many medical centers are built around prototypical "Bradley buildings." The VA rushed to build these structures in the 1940s and 1950s for World War II veterans. Fifty years ago, these facilities were flexible and inexpensive, but today they provide a very poor chassis for the body of a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to-floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts. The Bradley hospital's central core has a few small elevator shafts that are inadequate for vertical distribution of modern services.

Much of the current vacant space is not situated in prime locations but is typically located in outlying buildings or on upper floor levels. The permanent structural characteristics of this vacant space often make it unsuitable for modern medical functions. VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved. Some space may be suitable for enhanced use. Some should be demolished. Each medical center should develop a plan to find suitable uses for its non-historic vacant properties.

VA should develop a comprehensive plan for addressing excess space in properties that are not suitable for medical or support functions due to its permanent characteristics or location.

Mr. Chairman and distinguished members of this Committee, this concludes my statement and I will be happy to respond to any questions you may have.



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TESTIMONY

of

**Richard Jones
AMVETS National Legislative Director**

before the

**Committee on Veterans' Affairs
U.S. House of Representatives**

on

The Independent Budget

and

**The Department of Veterans' Affairs Budget
for Fiscal Year 2006**

**Tuesday, February 16, 2005,
Cannon House Office Building**

Chairman Buyer, Ranking Member Evans, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations at this hearing on the VA's budget request for fiscal year 2006. My name is Richard A. Jones, National Legislative Director, and I am pleased to provide you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2006 programs of the Department of Veterans Affairs. AMVETS testifies before you today as a co-author of *The Independent Budget*.

For over 19 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Indeed, we are proud that over 40 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality health care. Veterans must be guaranteed access to a full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans healthcare system and to the advancement of American medicine.

In addition, the VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The VHA is the most cost effective application of federal healthcare dollars, providing benefits and services at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA.

Noting the mission of the VA, it is important to understand the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must address the continuing backlog in veterans waiting for health care and it must address, as well, VA's benefits casework backlog. There are severely disabled veterans and those needing home-based healthcare in those backlogs, and I think we can all agree that this situation should be addressed and corrected.

As we look to fiscal year 2006, we witness a live lesson about the challenges inherent in inadequate funding. VA says that action was taken, due to inadequate resources, to ban healthcare access to tens of thousands of veterans who are eligible to enroll in the very system put in place to serve them. The resource situation reaches the absurd when, after blocking entry to these so-called "high income" veterans, VA directs its workers under VHA Directive 2003-003, January 17, 2003, to send banned veterans to Community Social Work for assistance. For those brave men and women who once served to defend America's freedom, welfare has replaced their earned benefit.

Looking at the 2006 budget, released last week, AMVETS notes that the Administration is proposing an \$880 million increase in VA health care. More than 85 percent of the administration's proposed increase, \$768 million, comes directly from the wallets of veterans using the system, in the form of a new user tax and a doubling of prescription copayments for about 2 million veterans.

When stripped of the proposed new user tax and increased copay, the budget recommendation presents a paltry one-half of one percent increase above last year's funding—\$111.2 million—not even enough to cover the president's proposed federal pay raise for the medical staff that delivers veterans' health care. The result of these proposals, according to VA, would push 215,000 former servicemembers out of the very system designed for their care.

To avoid implementation of the proposed exclusion of these veterans, *The Independent Budget* recommends Congress provide \$31.2 billion to fund VA medical care for fiscal year 2005, an increase of \$3.5 billion over the Administration's request. We ask Congress to recognize that the VA healthcare system can only bring quality health care if it receives adequate funding. It is an excellent investment for America.

Not only would adequate funding allow VA to achieve its mission of providing veterans health care,

young Americans will see that our nation does not abandon its responsibilities to those who have served in armed defense of our nation. It would send a message that the contributions of servicemembers are appreciated above the priorities of non-defense, non-homeland security, and other non-veteran spending programs.

It is also important to clearly state that AMVETS along with its *Independent Budget* partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. We recommend this action because the current discretionary system is not working. Moving to mandatory funding would give certainty to healthcare services. VA facilities would not have to deal with the whimsy of discretionary funding, which has proven inconsistent and inadequate. Mandatory funding would provide a comprehensive solution to the current funding problem. Once healthcare funding matches the actual average cost of care for veterans enrolled in the system, with annual indexing for inflation, the VA can fulfill its mission.

The National Cemetery Administration

Before I address budget recommendations for the National Cemetery Administration (NCA), which is AMVETS's primary responsibility in the development of *The Independent Budget*, I would like members of the Committee to know that AMVETS is truly grateful to those who serve on this important committee. Through your work, you represent the veteran's voice. And as you lead the country in addressing issues important to veterans and their families, you may be assured that we will work with you and help report your leadership to the nation.

The members of *The Independent Budget* recommend that Congress provide \$204 million in fiscal year 2006 for the operational requirements of NCA, the national Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces. This recommendation includes the start of a five-year \$250 million program to restore and improve the condition and character of NCA cemeteries and, in total, is an increase—almost entirely aimed at improving the NCA Shrine initiative—of \$40 million over the Administration's request for next year.

Clearly, the aging veteran population has created great demands on NCA operations. Primarily

because of the mortality rate of World War II and Korean War veterans is increasing, as is the usage of burial services by Vietnam War Veterans, actuarial projections do not suggest a decline in these demands for many years. From current interment levels of 100,000 per year, the VA interment rate is projected to increase successively over the next several years peaking at 109,000 in the year 2008.

The National Cemetery Administration maintains more than 2.6 million gravesites in approximately 14,000 acres of cemetery land and inters more than 100,000 veterans annually. The NCA management responsibilities include 120 cemeteries: of these, 60 have available, unassigned gravesites for burial of both casketed and cremated remains; 26 allow only cremated remains; and 34 are closed to new interments.

Progress is underway at several sites around the country to complete construction of new national cemeteries. Funding is already in place for the Georgia National Cemetery, Atlanta, Georgia; the Great Lakes National Cemetery, Detroit, Michigan; the Southern Florida's National Cemetery, Miami, Florida; the Ft Sill National Cemetery, Oklahoma City, Oklahoma; the National Cemetery of the Alleghenies, Pittsburgh, Pennsylvania; and the Sacramento National Cemetery, Sacramento, California.

The administration's recommendations in the 2006 budget contain \$41 million of additional funding for land acquisition and related costs for six new cemeteries authorized under Public Law 108-109 to include sites at Bakersfield, California; Birmingham, Alabama; Columbia/Greenville, South Carolina; Southeastern, Pennsylvania; and Sarasota, Florida.

We ask for your strong commitment in supporting the administration's request for these funds in the congressional budget and final appropriations for the new year. With the opening of these new national cemeteries and state cemeteries, too, the percentage of veterans served by burial option within 75 miles of their residence will rise to 85 percent from a level of 73 percent in 2001, almost doubling the number of gravesites during this period.

The members of *The Independent Budget* are encouraged by the Administration's recommended increase in NCA resources for Fiscal Year 2005. It should be recognized, however, that while the administration's proposal adequately addresses employment increases and equipment needs, it

does not serve to address problems and deficiencies identified in the *Study on Improvements to Veterans Cemeteries*, a comprehensive report submitted in 2002 by VA to Congress on conditions at each cemetery.

Volume 2 of the *Study* identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the *Study*, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The total estimated cost of completing these projects is nearly \$280 million, according to the *Study*.

As any public facilities manager knows, failure to correct identified deficiencies in a timely fashion results in continued, often more rapid, deterioration of facilities and increasing costs related to necessary repair. The *IBVSOs* agree with this assessment and request Congress carefully consider this report to address the condition of NCA cemeteries. We recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems to ensure they remain respectful settings for deceased veterans and visitors. We recommend an establishment of a 5-year \$250 million program to complete projects identified in the *Study*.

Volume 3 of the *Study* describes veterans cemeteries as national shrines saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces. "The commitment of the nation," the report says, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual...even long after the visits of families and loved ones."

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries...shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43:24 1003(c)) Moreover, many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect

and nurture this national treasure, the system has and continues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

The State Cemetery Grants Program:

For funding the State Cemetery Grants Program, the members of *The Independent Budget* recommend \$37 million for the new fiscal year, an increase of \$5 million over the Administration proposal. The State Cemetery Grants Program is an important complement to the NCA. It helps States establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. The enactment of the Veterans Programs Enhancement Act of 1998 has made this program very active and attractive to the states.

Clearly, the enactment of the Veterans Benefits Improvements Act of 1998 has heightened the interest in the state cemetery grants program and increased participation of states in establishing fully equipped cemeteries for veterans. In fiscal year 2004, the state cemetery grant program had helped provide burial space for 19,246 burials of veterans and their eligible family members, an increase of nearly 5.6 percent over the prior year.

Currently, six new cemeteries are under construction in Boise, Idaho (the last state in the nation without a veterans' cemetery); Wakeeney, Kansas; Winchendon, Massachusetts; Killeen, Texas; and Suffolk, Virginia (serves 200,000 veterans in the Tidewater area). As before the 1998 legislative change, States remain totally responsible for operations and maintenance expenses to ensure conditions remain in a manner appropriate to honor the memory of veterans.

To augment support for veterans who desire burial in state facilities, members of *The Independent Budget* support increasing the plot allowance to \$745 from the current level of \$300. The plot allowance now covers less than 6 percent of funeral costs. Increasing the burial benefit to \$745 would make the amount nearly proportional to the benefit paid in 1973. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

The Independent Budget veterans service organizations (IBVSOs) also request Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from \$2,000 to \$4,100. Prior to action in the last Congress, increasing the amount \$500, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the nonservice-connected benefit from \$300 to \$1,270, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.



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February 15, 2005

The Honorable Steve Buyer, Chairman
House Veterans' Affairs Committee
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Buyer:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the February 15, 2005, Committee hearing on the VA's budget request for Fiscal Year 2006.

Sincerely,

Richard Jones
National Legislative Director



NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

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**STATEMENT
Of
NATIONAL ASSOCIATION FOR UNIFORMED SERVICES
On the
FY 2006 Department of Veterans Affairs
Budget Request
February 16, 2005**

Presented by

Major General William M. Matz, Jr., US Army, Retired
President

Disclosure

The National Association for Uniformed Services (NAUS) has not received grants (and/or subgrants) or contracts (and/or subcontracts) from the federal government for the past three fiscal years.

WILLIAM M. MATZ, JR.
MAJOR GENERAL, US ARMY, RETIRED
PRESIDENT
NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

Major General William M. Matz, Jr., Retired, was born in Drexel Hill, Pennsylvania. Upon graduation from Gettysburg College, he was commissioned a second lieutenant and assigned to the 82nd Airborne Division. Following this initial assignment, he served along the demilitarized zone in Korea with the 1st Battalion, 8th Cavalry, 1st Cavalry Division and 2nd Battalion, 23rd Infantry, 2nd Infantry Division successively as a rifle company commander and battalion S3. Upon his return from Korea, he was assigned to the Ranger Department, U.S. Army Infantry School. In October 1967, he arrived in Vietnam and served as a rifle company commander with the 3rd Battalion, 47th Infantry, 9th Infantry Division, in the Mekong Delta, where he was wounded in action during the 1968 Tet Offensive.

Upon return from Vietnam, he was assigned as Assistant Professor of Military Science, ROTC Department, Middlebury College, Vermont. MG Matz returned to WESTPAC in June 1970 where, as Plans/Special Operations Officer on the Afloat Staff, Amphibious Forces, Pacific Fleet, he planned and participated in amphibious operations along the Vietnam coast. In June 1973, he was assigned to the Strategy, Plans and Policy Directorate, ODCSOPS, DA, as a strategic planner and Directorate Executive Officer until assuming command of the 3rd Battalion, 187th Infantry, 101st Airborne Division in July 1977. In 1980, he returned to the 82nd Airborne Division and served as Division G3 from June 1980 to July 1982. Following this assignment, he returned to Korea where he served as Chief, Force Development Division, G3/J3, Eighth Army/U.S. Forces Korea Staff.

In 1983, he assumed command of the 4th Training Brigade, U.S. Army Armor School. Upon relinquishing command in 1985, he returned to the Army Staff as Deputy Director, Training Directorate, ODCSOPS. This was followed by a tour of duty as Executive Secretary to the Secretary of Defense. In August 1988, he became the ADC (S), 7th Infantry Division (Light), and deployed with the Division to Panama on Operation JUST CAUSE. MG Matz assumed duties as the Deputy Commanding General, U.S. Army Pacific in February 1990. He then served as the Deputy Commanding General and interim Commanding General of First Corps and Fort Lewis from November 1991 until his retirement from the U.S. Army in September 1995.

MG Matz is a graduate of the Infantry Officer Basic and Advanced Courses, the Airborne and Ranger Courses, the Command and General Staff College and the Army War College. He received a BA degree in Political Science from Gettysburg College and a MA degree in Political Science from the University of San Diego.

Among his awards and decorations are the Distinguished Service Cross, Defense Distinguished Service Medal, Distinguished Service Medal, Silver Star, Defense Superior Service Medal, Legion of Merit (with three Oak Leaf Clusters), Bronze Star for Valor, Purple Heart, and the Combat Infantryman Badge.

MG Matz and his wife Linda reside in Great Falls, Virginia, and are the parents of three married children.

Mr. Chairman, and distinguished members of the committee:

On behalf of the over 180,000 members of the National Association for Uniformed Services - NAUS, I thank you for this opportunity to present our members' views on the proposed budget for the Department of Veterans Affairs for Fiscal Year 2006.

The National Association for Uniformed Services (NAUS) prides itself in being "The Servicemember's Voice in Government - Focusing on People." NAUS is unique. Founded in 1968, it's the only military affiliated association whose members are representative of the entire military/veteran family. This provides a broad representation when dealing with Congress, the White House, and the Pentagon. NAUS represents all seven branches of the uniformed services: Army, Navy, Marine Corps, Air Force, Coast Guard, United States Public Health Service (USPHS), and National Oceanic and Atmospheric Administration (NOAA), including all components: Active Duty, Retired, Reserve, National Guard, and other veterans, their spouses, widows/widowers, other family members and survivors; and all grades and ranks - enlisted/officer.

The primary purpose of the National Association for Uniformed Services (NAUS) is to preserve and support a strong national defense by ensuring a high quality, well-trained volunteer military force. Our priority is to work hard to ensure our Active Duty, Veterans, Retirees, National Guard, and Reserve personnel receive their "promised" benefits. We strongly believe that doing this will greatly help in the recruiting effort of all the Services. Military retirees and veterans can be the military services' best recruiters, particularly, if they can pass on to prospective members of the Active and Reserve forces that our Nation keeps its promises to those who have served.

First, we advocate and support the implementation of a "Seamless Transition" for separating combat and other veterans. The services, especially the Army and Marine Corps, in concert with the Department of Veterans Affairs, have made great strides to ensure that returning Operation Iraqi Freedom & Operation Enduring Freedom combat veterans, as well as all other service men and women who complete their term of service or retire from the service receive timely access to Department of Veterans Affairs health care and benefits—but there is still work to be done. These military veterans should be "seamlessly" transitioned into the VA medical system and given all assistance possible to obtain their earned benefits so when asked, they can confidently report that a grateful nation does fulfill its promises. Much needs to be done including developing and deploying an interoperable, bi-directional and standards-based electronic medical record, a single-stop separation physical examination supported by an electronic separation document (DD Form 214), determination of VA benefits before separation from the Service, and a mental health examination and follow-up, coupled with a record of occupational exposures for possible future mental health problems.

Next, NAUS advocates full funding for the Department of Veterans Affairs Health Program. With the increase in discharged Active and particularly Reserve personnel that are now being added to the system, the demand for access to VA health care continues to exceed what the VA can deliver in a timely manner. As recommended by the May 2003 Presidential Task Force Report, the VA should have full funding to provide health care for all enrolled veterans. To have the funds necessary, the budget for the Department of Veterans Affairs should include modifications to the current budget process to provide mandatory funding for veterans health care. We know that the recent request from the Department of Veterans Affairs includes proposals for 2006 that would add a \$250 annual enrollment, and increase the pharmacy co-pay to \$15 for priority 7 and 8 veterans already enrolled in the system, but the full funding of VA health care would prevent this from happening. While we understand that there are budget restraints upon the Department and the priority must always be given to those veterans with the most need, we would ask your committee to study these proposals closely, and explore ways to open the system for new enrollees in all categories. This will guarantee that all veterans, including those serving today, will have some level of access to VA Health Care, and it will prevent any impression that the current warfighter is being pitted against veterans. We applaud the proposals to drop co-pays for POWs, and for those veterans in hospice care. We also appreciate the proposal that would authorize the VA to pay co-pays for emergency care for enrolled veterans at private hospitals.

One item we question in the proposed budget is the "assumption" that administrative "efficiencies" and improved collection efforts will increase at the rate stated. In real terms the VA budget has little or no increase in funding from the Government side. All of the increases in funds will come from the veterans themselves; from the increase in co-pays, enrollment fees and collections from insurance and other health plans the veterans may have. This does not reflect Abraham Lincoln's pledge "to care for those who have borne the battle." Rather, this says, "We will take care of you but you have to help pay for it". This might be acceptable to some veterans who can afford it, but what about those just on the edge of poverty, where in some instances someone making \$25,000 a year in retirement is considered wealthy by VA rules. This budget needs an increase in funding from the Government. If the VA wishes to concentrate on the core disabled and injured, NAUS will certainly accept that. However, those already enrolled should be taken care of at the same level promised when they entered the VA Health Care System. Many gave up other medical coverage and because of these proposed changes, may not now receive the affordable care they need and were promised at enrollment. Any changes in co-pays, enrollment fees, etc., should only affect future users of the system. NAUS would suggest that it is unfair to saddle current enrollees with paying the additional costs to raise the funds that are required to make this budget work.

While NAUS strongly advocates not making these changes for those currently enrolled, we understand that changes may be necessary. If this is the case, then the committee may want to further define priority 7 and 8 veterans to ensure that appropriate copays and or enrollment fees are only applied to those that can afford it based on the required VA Means Test. Under the current proposal, these cost increases would apply to ALL priority 7 and 8 veterans in the system.

As a way to open the system for more veterans and bring additional funding into the system, NAUS supports an initiative that provides for the reimbursement by Medicare to VA under Medicare Subvention for those non-disabled, Medicare-eligible veterans who prefer to use their Medicare benefits at a VA facility. We recommend the Congress enact the technical authority to implement Medicare Subvention and test the direct use of Medicare funds at VA facilities.

To meet the need for providing educational benefits through the Montgomery GI Bill (MGIB) to a new reality of an operationally integrated force of active duty and reserve components, a more up-to-date GI Bill of education benefits should be developed. Active duty GI Bill benefits have not kept pace with the rising cost of post-secondary education. Senior active duty service members who declined to sign up for the VEAP benefit in the late 1970's and 80's have been unfairly denied the opportunity to enroll in MGIB benefits. For members of the Reserves and National Guard, the MGIB benefits have been degraded to less than 29% of the 47% active duty benchmark. Also, Reserve and National Guard benefits have no post-service value as a veterans' benefit, though almost one-half of the Selected Reserve, which is now more than 400,000, have served on extended combat deployments. NAUS supports a new approach to the GI Bill to support recruitment needs and provide benefits commensurate with the length and type of enlistment contract and risks experienced by the Reserves and Guard in mobilization and deployment.

Another much needed improvement for the Department of Veterans Affairs is the restoration of additional claims worker positions for the VA staff to process the disability and survivor claims backlog. Also needed is funding for improved processing technology so that the VA can meet established performance standards and maintain or exceed this standard for processing claims in the future.

An issue that affects members of NAUS and its affiliate, the Society of Military Widows, is the retention of Dependency and Indemnity Compensation (DIC), if remarried. Previously passed law authorized DIC to remarried surviving spouses at age 57. To attain parity with other federal survivor programs, we support legislation to lower this age to 55 to retain DIC status and benefits.

On a related survivor issue we would recommend an increase in the amount of DIC payable to widows of Catastrophically Disabled Veterans to match other Federal survivor's benefit plans. Catastrophically Disabled Veterans, whose spouses serve as primary caregivers, receive additional allowances due to the severity of their service-connected multiple disabilities. These spouses often perform full-time primary care duty, which precludes them from regular work resulting in a retirement or Social Security benefits in their own right. When the veteran dies, the widow's income is reduced to the same DIC payment that other surviving spouses of veterans receive, whose death was service connected. The percentage of replacement income can be as little as 15%. The income replacement of other federal survivors' benefit plans is close to 50% of the benefit upon which they are based. Congress should provide for widows of Catastrophically Disabled Veterans on a similar basis.

We would also recommend the establishment of a survivor's office in the VA. A single point-of-contact office in the VA should be created solely to help survivors of veterans understand and apply for any benefits they are entitled to receive.

One last issue that affects those in the active force and with great bearing on those called to active duty from the Reserve and Guard is strengthening of rights under the Uniformed Services Employment and Reemployment Rights Act and the Servicemembers' Civil Relief Act which are under the jurisdiction of the Veterans Affairs Committee. Because of the duration of large scale Reserve and Guard call-ups, the committee should consider legislation to strengthen the protections afforded by these two acts, so that servicemembers called to active duty do not experience hardships while serving their Nation.

We at NAUS also request joint action by the House of Representatives and Senate to work together to codify the rules for burial in Arlington National Cemetery to preserve the special aspect of the Nation's most hallowed resting place, so that they are not subject to political considerations.

The 180,000 members of the National Association for Uniformed Services join me in thanking you, Mr. Chairman and the members of the House Veterans Affairs Committee for your previous support of the veterans' programs and ask that you join us in our support for improvements to these programs so that those who have served their country will report that their Nation supported them. We recognize and appreciate your longstanding personal commitment on behalf of the men and women who have defended this great country, and we appreciate your support of these key issues of importance to military beneficiaries and veterans.



STATEMENT

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

on the

FY 2006 Department of Veterans Affairs

Budget Request

before the

Committee on Veterans Affairs

U.S. House of Representatives

February 16, 2005

Presented by

Colonel Robert F. Norton, USA (Ret.)
Deputy Director, Government Relations

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One Powerful Voice.®

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE. On behalf of the nearly 370,000 members of the Military Officers Association of America (MOAA), I am honored to have this opportunity to express our views today concerning the administration's FY 2006 Dept. of Veterans' Affairs Budget Request.

MOAA does not receive any grants or contracts from the federal government.

VETERANS HEALTH CARE BUDGET

Overview. The FY 2006 VA Medical Care Budget includes \$28.1 billion in discretionary appropriations and \$2.6 billion in increased collections for a total of \$30.7 billion for VA medical care. With the collections, the VA medical care budget increases by only 2.5% compared to FY 2005. The Budget projects a drop of 203,000 veteran patients from the system due to the imposition of an annual usage fee of \$250 and increased drug copays on lower priority veterans. Overall, assuming medical inflation and increased usage by disabled and other higher priority veterans, as shown in the Budget, MOAA is concerned that the VA Medical Budget Request reflects negative growth between FY 2005 and 2006.

Strengths and Opportunities

Quality and Safety. By many measures, the VA health care system leads the nation in quality of care and patient safety (see, for example, Washington Monthly, Jan / Feb 2005: "The Best Care Anywhere"). MOAA notes that the FY 2006 VHA Budget sustains or slightly increases "key performance measures" (access standards, including primary and specialty care appointments, and so forth) and includes an increase of \$975.2 million to support care provided in community-based outpatient clinics (CBOCs).

Care for Enrolled Veterans. The Budget projects an increase in demand of veteran patients (system "users") with disabilities, special needs, Purple Heart recipients and the indigent. In FY 2005 3.6 million veterans in these groups received care and the Budget projects an additional 107,000 veterans – 3.7 million total – who will receive care in FY 2006. The Budget, however, projects a decline of 203,000 veteran patients in the lower priority groups, PG 7s and 8s, from 1.2 million users in 2005 to just over 1 million in 2006. This issue will be addressed later in this statement.

Mental Health Care. Recent studies project that 1 out of 6 servicemembers returning from Iraq and Afghanistan will need care at some point in their lives for PTSD and other mental health conditions. The Budget begins to address the growing need for additional clinical capacity for mental health services for veterans and their families. It includes an increase of \$100 million in obligations over 2005, and funds an additional 627 Full-Time Equivalent (FTE) positions to support the VA's Mental Health Strategic Plan.

Planning, Care and Support for Separating Servicemembers and their Families – “Seamless Transition”. Thanks in part to the work of the President’s Task Force (PTF) to Improve Health Care Delivery for Our Nation’s Veterans (May 2003), and the efforts of former VA Secretary Tony Principi, DoD and VA have taken further steps to improve the coordination of care and services to separating Active Duty, National Guard, and Reserve servicemembers and their families. MOAA notes that a senior level DoD – VA planning and coordination structure is now in place and other initiatives are being realized to some degree. Much more needs to be done, however, to ensure that DoD and the VA work more closely together to assist and support those who have “borne the battle, and their widow(er)s and orphans.”

CARES – Capital Asset Realignment for Enhanced Services. In May 2004, the Secretary of Veterans Affairs announced the national plan to support the CARES process. The Budget includes \$750 million in new construction for CARES. MOAA urges continued emphasis on the key letter, “E”, in the CARES acronym: enhancement of services for those who have worn the nation’s uniform.

Exemption from Co-pays and Emergent Care Reimbursement. MOAA is pleased to note that the Budget Request proposes to eliminate co-payments for veterans receiving hospice care and for former Prisoners of War. In addition, the budget includes a provision to allow the VA to pay for emergency room care received in non-VA facilities for enrolled veterans.

Challenges and Concerns

Enrollment Policy During a Time of War. MOAA recognizes that the Veterans Eligibility Reform Act of 1996 distinguishes between veterans who “shall” be provided care and those for whom the VA “may” provide care, if Congress agrees to fund their care. When the new enrollment system was implemented in 1998 and continuing through late 2002, the VA -- under two different administrations -- invited all honorably discharged veterans to enroll. This policy doubled enrollment and sharply increased demand for care.

Open enrollment was a deliberate policy decision that enabled the VA health system to transform from a hospital-based, “fix what’s broken” delivery model to an outpatient-oriented system with hundreds of new VA community-based clinics. With the exception of severely disabled veterans, all enrollees had to agree to pay drug co-payments for non-service connected prescriptions. Enrollees were not required to pay usage or enrollment fees.

Although Congress increased VA funding during and after the open enrollment era, there were insufficient funds to keep pace with the rising demand. Waiting lists increased to unacceptable levels. Consequently, VA took steps to “triage” demand. It closed future enrollment to a newly established Priority Group 8 category. Later, it instituted policies to ensure disabled and other higher priority veterans had assured access to VA appointments, a policy MOAA supported.

The Budget Request estimates that the proposed usage fees and higher drug copays will drive about 203,000 Priority Group 7 and 8 enrolled veterans from the system. Although some of these veterans may have other health insurance options, others do not. They accepted the VA’s offer to get their care in the system and now they should not be forced to take on increased fees to ensure their continued access.

MOAA is disappointed that the VA Budget Request proposes to impose an annual \$250 usage fee on lowest priority veterans whom it earlier had welcomed into the system to help it meet its transformation goals. For many of them, the imposition of the fees will be perceived as a “bait and switch” tactic.

MOAA believes that the imposition of a \$250 annual usage fee on some enrolled veterans sends the wrong signal during a time of war to our nation’s warriors past, present, and future. We urge the Committee to exempt all currently enrolled veterans from annual usage fees and higher drug copays.

Full-Funding for All Enrolled Veterans. MOAA is disappointed that the administration has not taken more aggressive action to implement the strong recommendations of the PTF that Congress provide full funding for all veterans enrolled in Priority Groups 1-7 and resolve the situation of Priority 8 veterans’ care. Sadly, however, it appears that little attention has been paid to this recommendation. No legislation has been proposed by the administration to establish full funding for enrolled veterans – either by a mandatory mechanism or some other means as recommended by the PTF.

MOAA continues to recommend that the Committee and Congress respond to the recommendations in the PTF Report by establishing a stable, sustainable funding mechanism to ensure for the care of all veterans the VA has accepted for care.

New Generation of Veterans. Since September 11, 2001, the nation has sent hundreds of thousands of service men and women into harms way. Many troops are on their second or third rotations to combat zones in Iraq and Afghanistan and more than 10,000 have been physically wounded.

The toll on the wounded in mind and spirit is not precisely known, but experts predict that one out of six soldiers will require mental health care now or in the future.

The VA has responded to this growing demand by waiving all enrollment criteria for separating troops who have served in a combat theatre. Returning veterans are enrolled in Priority Group 6 for two years. If they receive a service-related disability rating during that time, they may continue to receive care in PG 1 to 3.

Among the returning combat theatre veterans are more than 470,000 men and women of the National Guard and Reserve forces who qualify as veterans as a result of their service in the Afghanistan and Iraq campaigns.

Earlier in this testimony, we noted that the VA Budget projects an increase in resources for mental health services. Overall, however, the budget understates the growing demand for health services, projecting only an additional 107,000 users (PG 1-6) between FY 2005 and 2006. Based on VA enrollment data of returning combat veterans under the two-year “open enrollment” policy, however, it’s almost certain that there will be substantially higher demand on the VA system.

MOAA strongly urges Congress to provide additional resources to meet the needs of separating servicemembers during the ongoing war on terror and to plan for sufficient additional resources for the care of those returning from repetitive deployments.

'Seamless Transition' Initiatives Must Include Family Needs. MOAA continues to support DoD-VA efforts to improve health care and services for our servicemembers as part of the shared goal of achieving 'seamless transition'. While much has been done, there is an urgent need to provide more outreach and support to returning servicemembers and their families, particularly those severely wounded. Responsibility for support is a shared responsibility between multiple offices and agencies within the DoD, and the Departments of Veterans Affairs and Labor communities.

The impact on spouses and family members and the decisions they will have to make when they learn their loved one in the military has been injured are tremendous. A care management approach that helps these families navigate complicated health care, benefits, employment and transition systems and programs will help alleviate some of the enormous burdens these families must bear.

MOAA urges Congress to provide the necessary resources to ensure DoD and VA have the appropriate education, training, pre-clinical and consultations services, including family counseling, screening, and clinical services to meet the longer-term medical and support needs of our combat veterans and their families.

Policy, Planning and Technical Support of 'Seamless Transition'. Veterans of past conflicts often got sub-par services due to lack of adequate procedures, policies, and technologies supporting their transition from the armed forces into the VA. Given the unknown duration of the war on terror, there is a unique opportunity today to fix processes that in the past have hampered the delivery of services to our nation's servicemembers and veterans. The PTF made a special point of highlighting the importance of getting transition services right not only for our nation's veterans but to also to advance the more effective and efficient use of taxpayer resources.

As a nation, we have the technical capacity to develop and implement seamless transition initiatives. A country that can place robots on Mars to explore that distant and hostile environment, can, if there is a shared sense of urgency, refine and improve the technology and processes that support transition from military service. These initiatives include development of bi-directional, electronic medical records between the DoD and the VA, expansion and standardization of the benefits-delivery-at-discharge (BDD) program, a "one-stop" separation physical, and an electronic DD-214 service record.

MOAA recommends that the Committee arrange for a joint full Committee hearing with the Committee on Armed Services to review progress on "seamless transition" initiatives and to identify funds and other resources to accelerate improvement of services for separating veterans.

Gaps in CARES. MOAA and others have noted that the CARES planning process does not include planning for mental health services and long-term care. MOAA continues to urge

inclusion of those requirements in ongoing facilities decisions resulting from the CARES process.

CARES and DoD Facilities Planning Process. The VA Budget Request includes \$15 million to advance DoD – VA facilities collaboration. It is not clear whether ongoing or planned projects have been integrated in the CARES process or DoD’s preparation for the next round of military base realignment and closure -- BRAC. MOAA maintains that these collaborative projects must include as an outcome measure the enhancement of service to eligible veterans and servicemembers.

MOAA urges the Committee to closely monitor use of funds for VA-DoD facilities collaboration and to judge sharing projects on whether they improve access and quality of care for all eligible beneficiaries.

Medical Care Collections Fund (MCCF). The Budget Request projects a very large increase of \$635 million in MCCF, a hefty 32% increase over 2005. The Budget indicates some of the increase is attributable to a consolidation of other accounts into MCCF. However, the Budget does not present much backup information to substantiate how the projected MCCF increases will be realized. The Budget Request is banking largely on the MCCF to achieve a 2.5% increase in the VA medical care business line, but MOAA must question the reliability of the projection without additional detail on how this will be achieved.

Shortages of Medical Professionals. The Budget Request projects a decline of nearly 1100 registered nurses between 2005 and 2006. With the exception of a modest increase of 50 physicians, other disciplines show a decline including, LPNs, non-physician providers, health technicians / allied health specialists, and other FTE service delivery positions. The Budget includes initiatives to help address nursing and other shortages. These may indeed help, but the Committee may need to target additional resources to sustain medical capacity going forward.

Preserving Access to Earned Health Benefits – no “forced choice”. MOAA appreciates the leadership shown by Congress in protecting dual-eligible veterans’ access to all earned health care benefits. Dual-eligible veterans are military retirees whose careers of service to the nation entitles them to lifetime health coverage under TRICARE and eligibility for enrollment in VA health care. However, some administration officials have recommended that military retired veterans should be compelled to relinquish one health benefit or the other, a concept we call “forced choice.”

A better solution is to develop effective reimbursement procedures between DoD and VA, and we note some progress in this area by the DoD – VA Health Executive Council. Agency-level coordination mechanisms must be designed in ways that foster budget coordination and reconciliation without placing the burden or the blame on the backs of those who have earned dual-access to VA and DoD health care services.

MOAA appreciates the Committee’s prior support in opposing “forced choice” proposals that would compel dual-eligible veterans to relinquish access to either DoD or VA-sponsored health care services.

VETERANS BENEFITS

Overview. The 2005 VA Budget Request includes \$37.4 billion for entitlement costs associated with benefits administered by the Veterans Benefits Administration (VBA). Additional funds are identified in the Budget Request for improving compensation claims processing and the management of benefits programs including disability compensation; pensions; education; vocational rehabilitation and employment; and life insurance.

Strengths and Opportunities

Burial Program. MOAA is pleased to note that the Budget Request includes funds for continued expansion and improvement of national cemeteries. The Budget contains \$90 million for construction projects, including funds for the purchase of land for six new national cemeteries in Bakersfield, CA; Birmingham, AL.; Columbia-Greenville, SC; Jacksonville, FL.; Sarasota, FL; and southeastern Pennsylvania; and expansion of the Fort Rosecrans Annex in Miramar, CA. The budget also includes \$32 million for new state cemetery grants.

Challenges and Concerns

Disability Claims: Quality and Process Improvements Needed. The VA Budget Request states that in 2004, initial VA claims averaged 120 days to process. But, 21% of all claims averaged over 6 months to complete. Achieving a consistent output of quality claims – reducing errors and making sound initial judgments -- has eluded the claims system. We note that the VA Budget supports an increase of 113 FTE in the claims business. However, the Budget states that the average time to process an initial claim will increase to 145 days in 2006 for a variety of reasons. This trend is going in the wrong direction and must be reversed to be fair to returning disabled veterans. Clearly, the VA needs to model the processes used by successful “tiger teams” and replicate them throughout the system. Additional investment in training, FTE, and technology also will be needed to reach sustainable quality and timeliness goals.

MOAA supports increases in claims-workers, technology, and training in the VA Budget to reach and sustain performance goals.

Survivor Benefits. MOAA appreciates the leadership of many members of Congress in recognizing that death gratuity benefits and Servicemembers Group Life Insurance (SGLI) limits are insufficient to help the survivors and dependents of our nation’s fallen defenders. MOAA is confident that most Americans recognize raising these benefits is the very least that a grateful nation can and should do for the survivors of those who have made the ultimate sacrifice. Large private sector companies typically provide free insurance equal to two years’ salary, up to some six-figure cap. Service men and women sent into harms’ way to protect the nation deserve no less.

MOAA recommends the Committee authorize \$100K of SGLI coverage free of charge to all who purchase \$300K, and guaranteed free \$150K coverage for all assigned to combat zone. If a premium increase is needed, MOAA strongly recommends that it be structured so that the government, not the servicemember, picks up the extra cost.

Stress on Armed Forces Recruiting and the Role of the Montgomery GI Bill

Rising pressures on the nation's armed forces – Active Duty, National Guard, and Reserve – are having an enormous impact on the ability of the Services to recruit and retain young men and women to military service. In January for the first time in ten years, the Marine Corps missed its recruiting target. The National Guard has fallen short of its annual enlistment objectives by more than 10% in the last two years.

MOAA appreciates the increases in enlistment and reenlistment bonuses Congress enacted in last year's National Defense Authorization Act (P.L. 108-767). More may be needed in that regard. In addition, we believe that the Montgomery GI Bill (MGIB) must be re-designed and improved to support armed forces recruiting and retention programs. With jurisdiction over GI Bill programs, the Committee can play a critical role in supporting the Services in meeting their recruiting goals.

Unlike earlier postwar GI Bill education programs, a fundamental objective of the modern MGIB is support of active duty and reserve forces recruitment. Now more than ever, the MGIB must be improved to help struggling recruiters “make mission” and sustain military readiness.

Active Duty MGIB (Chapter 30, Title 38 USC). On 1 October 2004, MGIB-Active Duty rates increased to \$1004 per month for 36 months of full-time study under a three-year or longer enlistment. Dept. of Education data show that the MGIB-AD covers only 63% of the cost of expenses at the average four-year public college or university education, assuming full-time use of benefits.

Active duty troops may use all of their MGIB benefits on active duty, but the reimbursement rate is actually lower than the rate they would get if they separated (Section 3032, Title 38 USC). A lower active duty reimbursement rate may serve as a disincentive to reenlistment.

Recommendations for the Active Duty MGIB:

1. **Benchmark MGIB-AD rates to the average cost of a four-year public college or university education.** Despite significant increases in MGIB benefits in recent years, benefits support only 63% of the actual costs of an education at the average four-year college or university. Benchmarking MGIB benefit levels to the cost of education would be a powerful tool for armed forces recruiting.
2. **Eliminate the MGIB-AD enrollment fee.** College students receive generous federal loans for their education from their government with no obligation of service to the nation and no upfront payments. Conversely, young Americans who volunteer to serve in the Armed Forces are automatically docked a substantial portion of their first year's pay in order to enroll in the MGIB-AD. If they decide to leave the service but do not use remaining MGIB-SR entitlement, there is no authority to recover the \$1200 fee.
3. **Enrollment Option for Career Servicemembers who Declined “VEAP”.** 63,000 career servicemembers on active duty today declined to enroll in “VEAP” – the Post-Vietnam Era Veterans Education Assistance Program (Chapter 32, 38 USC) – on the advice of military recruiters. In many cases, they were told that they would do better to invest the VEAP enrollment fee of \$2700 and wait to enroll in the coming Montgomery GI Bill. They deserve one opportunity to enroll in the MGIB prior to retirement.
4. **Equalize MGIB reimbursement rates for AD servicemembers with the reimbursement rates for veterans.** Section 3032 of Chapter 30 lowers reimbursement

rates for the MGIB for servicemembers who use their benefits on active duty under certain circumstances. At one time, this provision may have served a useful purpose, but today the authority results in inequitable benefit reimbursement if a servicemember takes courses or training on active duty to advance professional qualifications and attain personal goals.

5. **Transferability of Benefits.** About two-thirds of today's force is married. Many reenlistment decisions are based on family needs. MOAA supports the concept of permitting transfer of up to one-half of remaining MGIB entitlement to immediate family members for those who commit to serve a military career (e.g., those who commit to serve at least 14 years normally will later complete 20 or more years service).

Selected Reserve MGIB (Chapter 1606, Title 10 USC). MGIB-SR rates originally were set at 47% of MGIB-AD rates when the program began on 1 July 1985. That ratio was maintained for 14 years until 1999, when Congress enacted a series of rate increases for the MGIB-AD alone. Consequently, MGIB-SR rates began to drop proportional to AD rates and today the present ratio to active duty rates is 28.7%. On October 1, MGIB-SR rates received a COLA increase to \$288 per month for 36 months under a six-year Selected Reserve enlistment.

MOAA appreciates the increase in MGIB benefits for mobilized Guard and Reserve troops enacted last year. The FY2005 National Defense Authorization contains new authority for members of the Selected Reserve called-up to active duty to participate in the MGIB-AD on a proportional basis of 40% for 90 days service up to 80% for two years service. We believe, however, that more aggressive measures are needed to buttress recruiting among Guard and Reserve forces.

MGIB –Selected Reserve Recommendations:

1. **Restore proportional parity between the MGIB-SR and the MGIB-AD.** To support Guard and Reserve recruitment, MGIB-SR rates should be restored to about 50% of MGIB-AD rates and adjusted automatically with any future changes in the Chapter 30 program.
2. **Establish a transition or reenlistment benefit for the MGIB-SR.** The MGIB-SR has no value as a veteran's benefit since participants must remain in the Selected Reserve to retain eligibility. MOAA is grateful to Congress for the recent extension of the in-service usage period from 10 years to 14 years. However, due to the radically changed nature of reserve service, the MGIB-SR should be structurally aligned with the MGIB-AD. Servicemembers who complete their service agreement should be able to use remaining entitlement after separation; alternatively, benefit rates should be raised for those who agree to reenlist or extend their service.
3. **Permit Aggregate Active Duty Service in a contingency operation to qualify for MGIB-AD benefits.** P.L. 108-767 contains expanded authority for reservists who serve on active duty since 9/11 to qualify for pro-rated MGIB-AD benefits: 90 days to 12 months = 40% MGIB-AD; at least one year but less than two years = 60% MGIB-AD; two years = 80% MGIB-AD. Due to erratic and inconsistent call-up practices, Guard and Reserve troops who aggregate up to two years active duty since 9/11 should be afforded a full MGIB-AD enrollment opportunity if they agree to continuous Selected Reserve service as required in Section 3012 of Title 38 USC.

4. **Open licensing / certification tests and high technology courses to MGIB-SR participants.** Today's educational system provides students with the opportunity to enroll in a variety of nontraditional courses offered through multiple venues. To allow the Selected Reserve the flexibility to take advantage of these educational opportunities, the MGIB-SR rules should be amended to allow accelerated lump sum payments of 60% of tuition and fees for short term, high tech courses. In addition, participants should be able to use up to \$1000.00 entitlement for tests to obtain a license or certification. Both options are currently offered to the MGIB-AD participants, but not MGIB-SR participants.

MOAA urges the Committee to recommend additional resources to "re-tool" the MGIB for the 21st Century force. A total force on the battlefield – Active Duty, Guard, and Reserve – must be supported by a total force approach to the GI Bill for the benefit of recruiting and retention and the post-service transition of those who have worn the nation's uniform.

Retention of Dependency and Indemnity Compensation (DIC) for Remarried Spouses. MOAA commends this Committee and Congress for enacting legislation to allow retention of DIC for eligible surviving spouses who remarry after age 57.

MOAA supports lowering the DIC Remarriage Age to 55 to align the benefit with all other Federal survivor remarriage programs. MOAA recommends the Committee earmark the funding needed for this adjustment.

Conclusion

The Military Officers Association of America greatly appreciates the opportunity to present our views on funding priorities for the administration's FY 2006 budget submission for the Department of Veterans Affairs. MOAA is very appreciative of the support provided to servicemembers and veterans in the past and we look forward to working with the leadership of the Committee and its distinguished members to ensure full funding for veterans health care and benefits programs.

**STATEMENT OF
PETER S. GAYTAN, DIRECTOR,
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS
FY 2006 BUDGET REQUEST**

FEBRUARY 16, 2005

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present The American Legion's views on the Department of Veterans Affairs' (VA's) fiscal year 2006 budget request. The American Legion continues to advocate for adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. With young servicemembers currently deployed to more than 130 countries, it is the responsibility of this Committee to ensure VA is indeed capable of meeting its obligation to provide for America's veterans. The American Legion commends the Committee for holding this hearing to discuss this important matter.

Mr. Chairman, the quality of care provided through the VA Health Care System has improved considerably in the past few decades. VA has recognized the need to treat the nation's veterans with the highest quality of care possible and today VA hospitals are consistently recognized as the top providers of health care in America.

Although the quality of VA health care has improved, the current problem facing today's veterans who are turning to VA for their health care needs is inaccessibility. In recent years, veterans have experienced incredibly long wait times at VA health care facilities. In early 2003, the backlog of veterans waiting to be seen at VA health care facilities reached 300,000. The American Legion responded to this health care crisis by implementing the "I Am Not A Number" campaign that identified veterans who were dealing with long wait times, cancelled appointments and long commutes to VA facilities. It was our intention to remind VA that patients of the VA health care system are individual veterans deserving of care and not simply numbers on a list.

As a result of the "I Am Not A Number" campaign, leadership and staff of The American Legion visited VA health care facilities nationwide to meet with VA Administration and gain a better perspective of the challenges faced by VA in providing timely access to health care. The American Legion is continuing those visits and will have visited all VA hospitals within the continental United States by June 2005. National Commander Tom Cadmus will be issuing the third in a series of Reports on the Condition of VA Health Care in America that reflect the findings of the visits later this year.

It is important that VA be funded at a level that will allow it to improve accessibility not only to the current population of veterans but to those service members who are currently serving to protect the freedoms of this nation. In light of this demand, The American Legion recommends the following discretionary funding levels for fiscal year 2006.

**BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS FOR
DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2006**

Program	VA FY 2005¹ Appropriation	VA FY 2006 Request	Legion's FY 2006 Request
Medical Care Including:	\$30 billion	\$31 billion	\$34.1 billion (includes MCCF)
• <i>Medical Services</i>	\$19 billion	\$22 billion	
• <i>Medical Administration</i>	\$4.6 billion	\$4.4 billion	
• <i>Medical Facilities</i>	\$3.7 billion	\$3.9 billion	
• <i>Medical Care Collections</i>	\$2 billion (Offset)	\$2.6 billion (Offset)	\$2.6 billion (Supplement) ²
• <i>DoD/VA HCIF</i>		\$15 million	
Medical & Prosthetics Research	\$393 million	\$365 million	\$447 million
Construction	\$578 million	\$750 million	\$ 1.6 billion
• Major	\$442 million	\$590 million	\$327 million
• CARES (dedicated)	(\$341 million)		(\$1 billion Major and Minor)
• Minor	\$212.3 million	\$ 160 million	\$261 million
• CARES (dedicated)	(\$167million)		
State Extended Care Facilities	\$104.3 million	<u>MORATORIUM</u>	\$124 million
State Veterans' Cemeteries	\$32 million	\$32 million	\$42 million
NCA	\$273 million	\$290 million	\$274 million
Departmental Management	\$1.3 billion	\$1.1 billion	\$1.8 billion

¹ Includes 0.8% rescission.

² Third-party reimbursements should supplement rather than offset discretionary funding.

Once again, Congress has been given a proposed budget for VA that includes provisions that would place more of the burden of payment on the veteran. The FY 2006 proposed VA Budget would require a \$250 annual enrollment fee for Priority Groups 7 and 8 veterans. Under this budget proposal, two groups of eligible veterans would now be required to pay an annual fee to access the very health care system that was created to treat their unique needs. Those Category 8 veterans who escaped the shut out in 2003 and are currently enrolled in VA would now find themselves paying out of pocket to be treated at VA.

The FY 2006 Proposed VA Budget would also raise the pharmaceutical co-payment for Priority Groups 7 and 8 veterans to more than twice the current rate.

While The American Legion understands all too well the funding crisis within VA, the solution to this problem is not to balance the VA budget on the backs of America's veterans. The solution is to provide guaranteed funding for VA.

As a nation at war, The American Legion advocates increasing VA funding in FY 2006 to meet the increased health care demand of America's veterans. In response to the overwhelming backlog of veterans seeking care at VA, former VA Secretary, Anthony Principi was forced to prohibit enrollment of new Priority Group 8 veterans. Many of the recently separated service members, especially Reservists and National Guard personnel, will qualify as Priority Group 8 veterans and will be denied enrollment, unless they served in theaters of operation. However, this new demand for services places even greater demands on VA to provide timely access to quality medical care.

MEDICAL CARE

Today, there are nearly 25 million veterans. As more choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. The American Legion fully supported the enactment of Public Law 104-262, the Veteran's Healthcare Eligibility Reform Act that opened enrollment in the VA health care system. Many veterans who, until this time, were ineligible for VA health care were now able to enroll. Veterans recognize that VHA provides affordable, quality care that they cannot receive anywhere else.

The astronomical growth of Priority Groups 7 and 8 veterans seeking health care at their local VA medical facility resulted in over 300,000 veterans being placed on waiting lists regardless of their assigned Priority Group. FY 2003 saw the suspension of enrollment of new Priority Group 8 veterans due to this growth in enrollees. The American Legion does not agree with the decision to deny health care to veterans simply to ease the backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate budget.

Additionally, VA must be capable of providing health care to the new era of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. These young servicemembers have earned the right to health care through VA and we as a nation must ensure that that right is protected by fully funding VA. According to VA as of January 2005, 48,733 veterans of Operation Iraqi Freedom have presented themselves to VA for medical care. The cost of treating these veterans, and all enrolled veterans, is a continuing cost of war that cannot be ignored.

The American Legion recommends \$34.1 billion for Medical Care in FY 2006.

MEDICARE REIMBURSEMENT

Under current law, VA is required to seek third-party reimbursements for the treatment of enrolled veterans' nonservice-connected medical conditions. Upon enrollment, veterans are asked to provide information on their health care insurance coverage. Over half of the enrolled VA patient population lists the Centers for Medicare and Medicaid Services (CMS). However, current law prohibits VA from collecting from CMS for the treatment of enrolled Medicare-eligible veterans.

The American Legion recommends Congress authorize VA to collect third-party reimbursements from the Centers for Medicare and Medicaid Services.

MEDICAL CARE COLLECTION FUND

Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veterans Affairs (VA) Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. The MCCF is a depository for funds collected from third party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Government.

Funds collected through MCCF are also used as an offset rather than as a supplement to appropriations for the medical care budget. The efficient and timely collection of these reimbursable costs would greatly benefit the VHA in helping meet the demands for a severely impacted veteran's health care system. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery. By off-setting these funds the VA loses valuable funding that is not representative of the veteran population in VERA allocations (Priority Groups 7 and 8) nor does it allow for the full utility of collecting from Medicare, the largest health insurance provider.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used for operating funds. Instead, in developing a budget proposal, it appears that the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect to the VISNs and VAMCs.

The American Legion opposes reducing annual VA discretionary funding by the MCCF recovery estimate.

MANDATORY FUNDING OF VA MEDICAL CARE

The simple fact is that the Veterans Health Administration (VHA) does not have the funding needed to treat all veterans seeking care from VA. VHA operates under a constant cloud of fiscal uncertainty. Over the last several years, VHA has struggled to meet the increased demand

for care while staying within budget constraints. These budgetary uncertainties create problems within VA's health care system. Future spending projections, staffing levels, equipment purchases, structural improvements are all stalled if the funding is not a certainty.

In an effort to provide a stable and adequate funding process, The American Legion has joined with Nine other Veterans Service Organizations in support of mandatory funding for veterans' medical care.

The American Legion and the Partnership of veterans' service organizations adamantly believe VA Medical Care should receive annual guaranteed appropriations to meet the health care needs of VA's enrolled patient population. The adverse impact of continued inadequate discretionary funding on VA's ability to provide timely access to quality health care is well documented. The President's Task Force to Improve Health Care Delivery for our Nation's Veterans advanced two proposals – one advocates re-designation of VA medical care as mandatory funding (like Medicare or Social Security), rather than discretionary funding; the other recommends creation of an independent board to recommend the VA medical care annual funding needs.

The American Legion supports guaranteed funding of the VA health care delivery system.

G.I. BILL OF HEALTH

Over a decade ago, The American Legion offered its blueprint for VA in the 21st Century called the G.I. Bill of Health. The vision was to create a national integrated veterans' health care network accessible by all veterans and their dependents, including military retirees and their eligible family members. This bold plan called for Congress, beneficiaries, and third-party insurance providers to meet their respective fiscal obligations.

The first step called for enrollment of all beneficiaries seeking enrollment in the Veterans Health Administration (VHA). Enrollment would provide the VA Secretary with a quantified and defined patient population. Once enrolled, each beneficiary would identify how his or her health care coverage would be paid. If a beneficiary was eligible for full health care coverage paid for by just the Federal government (Medicare-eligible, 100 percent service-connected disabled veteran or military retiree), Congress would appropriate funds to cover that cost. However, if the beneficiary was eligible for full health care coverage paid by several Federal agencies (a Medicare-eligible, 100 percent service-connected disabled veteran, and a military retiree), Congress would make only one payment; however, the beneficiary would seek health care only within the VHA unless referred to the private sector for care. Medicare-eligible veterans choosing this option would be authorized to seek health care only from within VHA medical facilities (VA Advantage model).

Third-Party Reimbursements Contribute to the Costs

Those beneficiaries choosing to enroll, with private or public health benefit coverage, would identify their third-party insurance provider and would agree to meet all co-payments and deductibles described by their policy. Should the third-party insurer refuse to make reimbursements to VA for the treatment of nonservice-connected medical conditions, the beneficiary would be denied enrollment.

Uninsured Beneficiaries have Affordable Options

For those beneficiaries choosing to enroll with no health benefit coverage, VA would be authorized to offer affordable health benefit packages to meet their individual health care needs. The Secretary would establish the premiums for each health benefit package and could waive premiums on a case-by-case basis.

For those beneficiaries identified in title 38, United States Code, (USC) for the VA Secretary to provide care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those beneficiaries identified by the DoD Secretary to receive care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those Medicare-eligible beneficiaries, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. All other beneficiaries would be responsible for meeting their health care needs through co-payments, deductibles, premiums, or third-party reimbursements from public or private insurance providers. All revenue streams (Federal appropriations, co-payments, deductibles, premiums, and third-party reimbursements) would go to a Veterans Health Trust Fund, similar to the Social Security and Medicare Trust Funds.

The American Legion believes these are solid recommendations for improvement of VHA.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) AND MEDICAL CONSTRUCTION

MAJOR CONSTRUCTION UNDER CARES

Over the past four years, The American Legion has carefully followed the progress of the Secretary of Veterans Affairs' Capital Asset Realignment for Enhanced Services (CARES) process. CARES has been an incredibly complex national process to reorganize VA through a data driven assessment of veterans' health care needs through the years 2012 and 2022. CARES is the future of VA health care delivery of services that will, ostensibly, meet veterans' current and future health care needs. The American Legion has participated at each stage of the process by gathering information on VA Medical Centers throughout the country to make certain medical facilities were not closed simply to save money.

In May 2004, then Secretary Principi released his final CARES decisions and the implementation process is going forward. While The American Legion was not in total agreement with all the decisions made so far, we feel the process was fair due in large part to the hard work and input of The American Legion leadership, membership and national staff and that of numerous other stakeholders. As the implementation process continues, The American Legion is prepared to remain vigilant to assure that veterans are not deprived of their earned health care.

The CARES decision supports establishing new hospitals in three locations - Orlando, Las Vegas, and Denver. It also supports new bed towers in Tampa and San Juan, 156 new community clinics in 33 states and territories, a new multi-specialty outpatient clinic in Columbus, four new or expanded spinal cord injury centers and two new blind rehabilitation

centers. Included in the plan are the closures of the Highland Drive (PA), Brecksville (OH) and Gulfport (MS) facilities.

The American Legion believes VA should exercise caution during the planning phases for these closures. No doors should be closed for services before new services are in place and functioning. Contingency planning needs to take place and stakeholders should be involved in all aspects of the implementation of these closures. Through the CARES process over one hundred major construction projects were identified and submitted for review. VA prioritized these major capital investments through FY 2010. A plan of this magnitude requires a significant amount of resources to include trained and experienced personnel. This will have a major impact on VA's ability to move forward with the construction projects, even if they have the needed funding.

To successfully implement the CARES decision, VA has estimated that it will require an infusion of a \$1 billion per year for the next six years, with continuing substantial infrastructure investments well into the future. The American Legion is opposed to the CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for "special emphasis programs" like mental health, long-term care, domiciliary and homeland security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process.

CARES IMPLEMENTATION

Of the amount appropriated for medical care in fiscal year 2005, P. L. 108-477 authorizes the Secretary of Veterans Affairs (Secretary) to divert \$400,000,000 for the implementation of CARES under the Major Construction account. The American Legion strongly opposes the use of needed medical care funding for the implementation of CARES.

The American Legion recommends \$1.58 billion for Major Construction in FY 2006, including \$1 billion for CARES.

The American Legion supports a separate appropriation of \$1 billion per year for the next 6 six fiscal years for the implementation of CARES.

MINOR CONSTRUCTION

Similar to VA's major construction program, VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase over the previous funding level of \$211 million is crucial.

The American Legion recommends \$ 261 million for Minor Construction in FY 2006.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service has a history of productivity in advancing medical knowledge and improving health care not only for veterans, but for all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The VA Medical and Prosthetic Research budget has not kept pace with inflation during the past 15 years. It is essential that Congress and the Administration support strong medical and prosthetic research programs within VA so that veterans and all citizens continue to benefit from the exceptional research capability of the Department.

The American Legion supports adequate funding for VA biomedical research activities. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans - such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others - jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, academic institutions.

The American Legion recommends \$ 447 million for Medical & Prosthetics Research in FY 2006.

LONG TERM CARE

This year, VA adds three new legislative initiatives toward minimizing its financial responsibility to America's aging veterans.

ELIMINATE VA NURSING HOME CARE UNITS MANDATORY CENSUS REQUIREMENTS UNDER 38 U.S.C. § 1710B(b).

The Veterans Millennium Health Care and Benefits Act of 1999, P. L. 106-117, 113 Stat. 1545 (1999), (Millennium Act) (codified at 38 U.S.C. § 1710B(b)), requires VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. The American Legion does not believe this requirement of law constitutes a "baseline for comparison"; rather we maintain that the language in the law is quite clear.

(b) The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998.

This capacity has significantly eroded rather than maintained. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9795 beds in fiscal year 2006.

This issue has a contentious recent history.

It was charged in the House Veteran's Affairs Committee's (HVAC) FY 2004 Budget *Views and Estimates* that VA plans to do away with a large part of its existing LTC beds, to wit:

The Committee has been in regular communication with the Secretary concerning a noted decline in VA nursing home beds (approximately 2,000 beds). On May 8, 2002 the Secretary made a commitment to restore these beds to their prior level, provided that Congress appropriates an increase in VA's medical care appropriation for fiscal year 2003. In the omnibus appropriation approved by Congress on February 13, 2003, VA received \$1.1 billion more than what was requested by the President for the period.

The Committee is disappointed by the Secretary's proposal in this budget to close thousands of additional VA nursing home beds. VA's own long-term care model, based on the medical needs of its users, indicated a need for 17,000 new nursing home beds by 2020. The Committee does not believe that VA can replace 5,000 nursing home beds with outpatient programs for elderly, chronically ill veterans.

VA has never fulfilled the promise of its landmark mid-1980's study, *Caring for the Older Veteran*. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and noninstitutional bases. This has not been achieved.

In order to aid the Department in maintaining its current nursing home bed level, the Committee recommends that VA's budget request be augmented by an additional \$297 million. Furthermore, VA should fund effective alternatives to long-term care and reopen long-term care nursing beds that have been closed.

VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. In a February 2002 letter to HVAC Ranking Democratic Member Lane Evans, Secretary of Veterans Affairs Anthony Principi stated:

"I have come to the conclusion that as long as we continue to use VA inpatient average daily census (ADC) as the singular measure for long-term care capacity, it will not be possible for VA to meet the requirements of P.L. 106-117 without adversely affecting our ability to provide other essential health care services to veterans on a timely basis."

On March 20, 2002, the Secretary forwarded a plan to HVAC to restore VA NHCU bed capacity to the 1998 level including "substantial implications" for doing so. The cost was to be offset by forgoing planned expansion of contract community nursing care, decreasing education and research programs, reprogramming technology infrastructure requirements, transferring a portion of the SVH construction budget and converting intermediate medicine beds to NHCU beds. Following these "threats", HVAC replied on March 26 that it was prepared to recommend appropriation of additional funds to enable VA to comply with the law.

VA has made clear its determination not to expand its own Nursing Home Care Unit bed capacity; in fact, VA has defied Congress' mandate to maintain its 1998 bed capacity of 13,391. Instead VA's inpatient nursing home bed count now stands at 9795.

The American Legion supports the maintenance of VA Nursing Home Care Unit bed capacity at the 1998 level of 13,391.

STATE VETERANS HOMES PER DIEM

VA's Budget Request for fiscal year 2006 contains a legislative proposal that would restrict eligibility for State Veterans Homes (SVH) Per Diem payments for long term (maintenance) care to veterans in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4 veterans. Non-catastrophically disabled Priority Group 4 and Priority Groups 5 through 8 would be entitled to only short-term care. This is unacceptable to The American Legion.

The State Veteran Homes have been a successful cost-sharing program between VA, the States and the veteran. Veterans in SVHs tend to be without family, indigent and requiring of Aid and Attendance. One SVH has estimated that these eligibility criteria would cut its Average Daily Census by over 50 percent and cost the facility \$2 million per year. This proposal would spell financial disaster for SVHs and would result in a new population of homeless elderly veterans on our streets, especially in states with poor Medicaid nursing home reimbursement rates. It has also been suggested that a surge in claims for service connection would ensue as SVHs scramble to qualify veterans for inclusion in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent of the cost of nursing home and domiciliary care provided to veterans in State Veterans Homes and full reimbursement for veterans with 70 percent or greater service-connected disabilities. The American Legion also supports the provision of prescription drugs and over-the-counter medications to veterans with 50 percent or greater service-connected disabilities, along with the payment of authorized per diem to State Veterans Homes. The National Association of State Veterans Homes and VA should develop mutual planning efforts, enhanced medical sharing agreements, and enhanced-use construction contracts with qualified providers.

The American Legion opposes any legislative changes in the eligibility criteria for receipt of State Veterans Homes Per Diem.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

The fiscal year 2006 VA Budget Request contains zero dollars for the State Extended Care Facility Grants Program; instead VA would impose a one-year "moratorium" on grants for new facilities construction while VA completes a nationwide infrastructure assessment study of its institutional long term care. The American Legion agrees that such a study is long overdue; projections for long-term care inpatient capacity were largely left out of the CARES process. We fail to see the utility in suspending payment of construction grants in FY 2006, especially in states having never previously applied and in states having significant need.

State Veterans Homes were founded for indigent and disabled Civil War veterans beginning in the late 1800s and have continued to serve subsequent generations of veterans for over one hundred years. Under the provisions of 38 USC, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans Homes. Today, there are 109 State Veterans Homes facilities in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. The State Veterans Home Program has proven to be a cost-effective provider of quality care to many of the nation's veterans and this program is an important adjunct to VA's own nursing, hospital, and domiciliary programs. The Grants for Construction of State Extended Care Facilities provides funding for 65 percent of the total cost of building new veterans homes. VA has not been able to keep pace with the number of grant applications; currently there is over \$120 million in unfunded new construction projects pending.

Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system.

The American Legion recommends \$124 million for the State Extended Care Facility Grants Program in FY 2006.

NATIONAL CEMETERY ADMINISTRATION (NCA)

THE NATIONAL CEMETERY SYSTEM

VA's National Cemetery Administration (NCA) is comprised of 120 cemeteries in 39 states and Puerto Rico as well as 33 soldiers' lots and monuments. NCA was established by Congress and approved by President Abraham Lincoln in 1862 to provide for the proper burial and registration of graves of Civil War dead. Since 1973, annual interments in NCA have increased from 36,400 to over 84,800. Annual burials are expected to increase to more than 115,000 in the year 2010 as the veteran population ages. Currently 59 national cemeteries are closed for casket burials. Most of these can accept cremation burials, however, and all of them can inter the spouse or eligible children of a family member already buried. Another 22 national cemeteries are expected to close by the year 2005, but efforts are underway to forestall some of these closures by acquiring adjacent properties.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or state cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

P.L. 107-117 required NCA to build six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five, Atlanta, Detroit, South Florida, Pittsburgh and Sacramento are in various stages of completion. Additional acreage is currently under development in 10 national cemeteries, columbaria are being installed in 4 and additional land for gravesite development has been acquired at national cemeteries in 5 states. 9 national cemeteries are expected to close to new interments between 2005 and 2010. The rate of interments in national cemeteries has increased from 36,400 in 1978 to 84,800 in 2001. This rate is expected to rise to 115,000 in 2010.

The average time to complete construction of a national cemetery is 7 years. The report of a study conducted pursuant to the Millennium Act concluded that an additional 31 national cemeteries will be required to meet the burial option demand through 2020. Legislation is currently pending in this session that will authorize the establishment of 10 new national cemeteries in areas of the country facing a shortage of burial space. Together with the 6 national cemeteries under development, this will go a long way toward fulfilling this need. NCA will be able to keep pace with current demand for burial space if this legislation is enacted and fully funded this year.

The American Legion urges Congress to provide sufficient major construction appropriations to permit NCA to accomplish its mandate of ensuring that burial in a national cemetery is a realistic option for 90 percent of our nations veterans.

NATIONAL SHRINE COMMITMENT

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take 28 years to complete. The American Legion supports the goal of completing the NCA's National Shrine Commitment in five years. This Commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the National Cemetery Administration to fulfill this Commitment.

The American Legion recommends \$274 Million for the National Cemetery Administration in FY 2006.

STATE CEMETERY GRANTS PROGRAM

The National Cemetery Administration (NCA) administers a program of grants to states to assist them in establishing or improving state-operated veterans cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, the matched-funds program helps to provide additional burial space for veterans in locations where there are no nearby national cemeteries. Through FY 2002, more than \$169 million in grants have been awarded to states and the Territories of Guam and the Northern Marianas, including 5 new state cemeteries and the improvement and/or expansion of 9 existing ones.

Under the Veterans Programs Enhancement Act of 1998, P.L. 105-261, VA may now provide up to 100 percent of the development cost for an approved project. For establishment of new cemeteries, VA can provide for operating equipment. States are solely responsible for the acquisition of the necessary land.

The American Legion recommends \$42 Million for the State Cemetery Grants Program in FY 2006.

VETERANS BENEFITS ADMINISTRATION

The Department of Veterans Affairs has a statutory responsibility to ensure the welfare of the nation's veterans, their families, and survivors. Each year, the 58 regional offices of the Veterans Benefits Administration (VBA) receive over 100,000 new and reopened benefits claims. A majority of these claims involve multiple issues that are legally and medically complex and time consuming to adjudicate. Whether a case is complex or simple, these offices are expected to develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner.

CLAIMS BACKLOG

Last year we expressed concern about the probable effect of a major cut back in regional office staffing slated for FY 2004 and a further smaller reduction proposed for FY 2005. It did not appear that the available staffing resources were going to be sufficient to handle the additional workload associated with legislation enacted by this Congress affording new benefit entitlements, along with liberalized VA policy on diseases related to Agent Orange and required support for DOD's Combat Related Special Compensation Program (CRSC). There has also been an influx of new claims for service connection, due to the fact that enrollment in VA's medical care system remains closed to some Category 8 disabled veterans. Much of the overall increased workload, however, stems directly from the required rework of tens of thousands of pending and previously decided cases, due to precedent decisions of both the United States Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit.

The Veterans' Claims Assistance Act of 2000 (VCAA), P.L. 106-475, was designed to overcome deficiencies in the claims adjudication process, improve the way VBA communicates with claimants, and the way in which claims were developed. The basic goal was to ensure that VA regional offices provided individuals essential information concerning their claim, so that they would know what evidence they were expected to submit and what evidence VA would try and obtain. This legislation was expected to result in claims that were more fully developed and which could be adjudicated in a more expeditious and accurate manner. There was also an expectation that these improvements would increase claimant's satisfaction with the decision received and reduce the appeals workload for the Decision Review Officers and the Board of Veterans Appeals.

VBA has, over the last three years, begun aligning its policies and procedures to conform to the letter and intent of VCAA, and has directed most of the regional offices' time and effort toward reducing claims processing time and reducing the backlog of pending claims. Achievement of former Secretary Principi's stated goal of 100 days to process a claim, on average, and a backlog of 250,000 pending claims by the end of fiscal year 2003 has been and continues to be VBA's number one priority. To fulfill mandated production quotas, regional office management and adjudicators have been put in the difficult and unenviable position of having to choose between deciding thousands of cases as quickly as possible or going through the more time consuming steps necessary to comply with VCAA and provide the claimant full due process.

In October 2003, Former Secretary Principi announced that the claims backlog had been reduced to the promised target level. Claims processing times were also trending down toward the 100-day goal and the error rate was improving. From VBA's perspective, these results showed that

regional office service had improved dramatically. Part of Secretary Principi's promise was, once the backlog goal had been achieved, VBA would be able to shift time and attention to improving the quality of claims adjudication. However, experience has once again shown that "faster is not always better."

Unfortunately for thousands of veterans and their families, their rights under the VCAA have been subordinated to bureaucratic convenience for the sake of an arbitrary administrative goal. This persistent disregard of the law prompted thousands to file otherwise unnecessary appeals. Since judicial review of veterans' claims was enacted in 1988, of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC), the remand rate, historically, has been about fifty percent. In a series of precedent setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, the courts have invalidated a number of longstanding VA policies and regulations because they were not consistent with the statute. In response to these decisions, VBA provided the regional offices with revised templates for VCAA notices to conform to the directives of the court. Unfortunately, VA's notices still do not adequately fulfill the notice requirements of the VCAA.

These court decisions immediately added thousands of cases to regional office pending workloads, since they require the review and reworking of tens of thousands of completed and pending claims. Between October 2003 and December 2003, the case backlog increased from 250,000 to 350,000. From January to August 2004, the number of pending claims has been reduced only by some 25,000 cases. However, over the same period, the number of appeals pending in the regional offices has grown by 20,000 cases. Data on regional office performance appear to contradict VBA's description of improvements in service to veterans.

LACK OF QUALITY DECISION MAKING IN VBA

The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VA's FY 2005 budget request noted the fact that VBA has lost much of its institutional knowledge base over the past four years, due to the retirement of many of its 30-plus year employees. Retirements among this group are expected to continue at a significant rate in 2005. As a result, staffing at most regional offices is now made up mostly of trainees, with less than five years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their basic training.

The American Legion's visits to regional offices have found that, frequently, there have been too few supervisors or inexperienced supervisors to provide trainees necessary mentoring, training, and quality assurance. In addition, at many stations, ongoing training for the new hires as well as the more experienced staff would be postponed or suspended, so as to focus maximum effort on production. Despite the fact that VBA's policy of "production first" has resulted in many more veterans getting faster action on their claims, the downside has been that tens of thousands of cases have been prematurely and arbitrarily denied. As a consequence, the appeals burden at the regional offices, the Board and the Appeals Management Center (AMC) continues to grow. What must also be kept in mind is that there is a disabled veteran, most often with a family, behind each one of these appeals, who has been fighting the VA system for a year, two years, or more to get what he or she feels they are rightfully entitled to.

The American Legion was very disturbed by information presented at the July 2004 VBA Leadership Conference about regional office adjudicators' job performance. VBA had two groups of Veterans Service Representatives (VSRs) take a job skill certification test. There were 650 individuals tested. They were GS 10 and GS 11 with three to five years of regional office claims experience and were considered to be proficient workers. It was, therefore, very disconcerting to learn that only 25 percent of the GS 10s and 29 percent of the GS 11s passed the open book test. If these individuals are supposed to be VBA's best and brightest adjudicators, it is little wonder that appeal workload continues to rise, the combined overturn rate at the Board of Veterans' Appeals continues to be extremely high. From these results, it appears that, despite having spent millions on its adjudicator-training program, this effort has not succeeded in correcting the many problems that contribute to poor quality decision-making and create unnecessary appellate work. Rather than providing a solution to the problem, the deficiencies in training and the lack of effective quality assurance continue to fuel the growing backlogs.

APPEALS MANAGEMENT CENTER

As a result of a successful legal challenge to the establishment of a unit at the Board of Veterans' Appeals (Board or BVA) to undertake needed development of appeal cases, VBA established the AMC. Its purpose is to provide more expeditious action on remands and also to relieve the regional offices of the workload burden associated with remands. The AMC basically functions as a national regional office for this type of case. It undertakes the additional development of evidence specified by the Board and readjudicates the claim. With a staff of 82 FTEs the AMC is overwhelmed by a growing volume of cases. Initially, 16,484 cases were inherited from the now-defunct BVA development unit and, currently, the AMC has a total of 22,002 remands under development. As a result, VBA recently established AMC resource centers in St. Petersburg, Cleveland, and Huntington to assist with its enormous backlog. Although it is too early to comment on the productivity or quality of work produced by these resource centers, questions remain as to the AMC's overall ability to produce quality and timely work in the face of the continually increasing backlog and the growing pressure to reduce it.

While the AMC is an admirable attempt by VBA to improve service to veterans, it does nothing to address the problems underlying the continued rise in the number of appeals and remands by the Board of Veterans Appeals. In our view, the very necessity of the AMC's existence begs the question – why hasn't VBA mandated the regional offices to correct their own mistakes?

This new super regional office is now responsible for correcting errors that the regional offices were unwilling or unable to do. However, the AMC has no authority to prevent the same type of error, which prompted the appeal and remand, from occurring again. It is worth noting that regional offices did not receive any work credit for remand actions. This should have been an incentive for local management to try and improve decision-making and avoid appeals and potential remands. Experience has shown just the opposite.

Since production work on new claims were the highest priority and there was no work credit for remands, many regional offices simply ignored their appellate workload with remands pending for two and three years. Now, there is still no clear incentive for the regional offices to improve quality. They are continuing to forward new cases to the Board where almost sixty percent are being remanded to the AMC. VBA must ensure that the regional offices are held accountable for

the poor quality of initial decision-making and development of appeals and not allow them to shift the workload onto the Board of Veterans Appeals and, ultimately, the AMC.

BOARD OF VETERANS' APPEALS

The BVA is a separate entity within VA. Its responsibility is to render a final decision on the propriety of a regional office decision. If the Board determines a final decision cannot be made on a case due to inadequate or incomplete development, including lack of due process, it has the authority to remand the case back to agency of original jurisdiction, which now includes the AMC, for additional required development and readjudication.

Regional office appeals and dispositions by the Board are a direct reflection of the level of claimant satisfaction or dissatisfaction with and confidence or lack thereof in the fairness and propriety of regional office adjudication. It is, therefore, painfully obvious that the level of dissatisfaction is substantial and growing, in view of the increasing number of new appeals coming into the system.

To ensure VA and VBA are meeting their responsibilities; The American Legion strongly believes that Congress must scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

Mr. Chairman, this concludes my testimony. I again thank the Committee for this opportunity to express the views of The American Legion on VA's FY 2006 Budget Request and look forward to working with you and the Members of the Committee to ensure VA is funded at a level that will allow all veterans to receive the care they have earned through their service.



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February 16, 2005

Honorable Steve Buyer Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the February 16 hearing, concerning The Department of Veterans Affairs' FY 2006 Budget Request.

Sincerely,

Peter S. Gaytan, Director
Veterans Affairs and Rehabilitation Commission



Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS of AMERICA

Submitted for the Record by

Thomas H. Corey
National President

Regarding

The Department of Veterans Affairs
Fiscal Year 2006 Budget

Before the

House Veterans' Affairs Committee

February 16, 2005

Mr. Chairman and other distinguished Members of this Committee, on behalf of the membership of Vietnam Veterans of America (VVA), I am pleased to submit our views with respect to the President's budget proposal for FY'06 as it pertains to the funding of programs of relevance and concern to veterans and their families. VVA thanks you for the opportunity to provide this statement, and for considering our thoughts in this important matter.

This Administration has trumpeted the increases in funding for the operations of the Department of Veterans Affairs in the past four years. It is true that in President Bush's first term, appropriations for veterans' affairs have increased by more than 40 percent. Some of those increases were in mandatory funding, some were in increased collections from veterans and third-party payments. But there have been substantial increases in funds for medical care. Yet these increases have failed to keep pace not only with medical inflation, but also with the increased demand for services by veterans statutorily eligible for care and treatment by the VA. The per capita funding for a veteran at VA has lagged far behind even the increases provided to Medicare recipients, which is so inadequate that providers continue to drop out of that system.

In fairness to the President, he inherited an inadequate budget base, due to the flat line funding of veterans' health care during his predecessor's second term. It appears that another few years of flat line medical budget proposals are in our future yet again. Certainly Undersecretary of Defense David Chu's public statement portends this attitude, especially in light of the fact that neither the President nor anyone else in the administration moved to neither rebuke Mr. Chu for his remarks nor to distance themselves from his remarks demeaning and slandering those who have served our nation honorably and well in military service. It appears that this unfortunate and disgraceful pattern of second-term neglect and irresponsibility is about to repeat itself.

We see the writing on the wall in the President's budget proposal for FY 2006. The "enhanced restraint" touted by the Office of Management and Budget (OMB) bodes ill for veterans. This restraint eliminates, on paper, more than one million veterans from the VA health care system. Men and women who are categorized as Priority 7 and 8 veterans, who have no service-connected disabilities but whose economic fortunes are tottering or who do have service-connected disabilities but are rated as 0 percent compensable at the present time.

It is an affront to term these men and women "higher income" veterans. Most make less than \$40,000 per year; most have no health insurance. Otherwise they would likely not seek help from the VA health care system. VVA points out that these are also the men and women who account for some 40 percent of the third-party reimbursement to VA coffers. The marginal cost of including these veterans in the system actually may produce more income than they cost the system, as they tend to be less sick when they seek help from VA. Most importantly, they are men and women who have served our

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country honorably and are statutorily eligible for care and treatment. Yet they are being denied that earned entitlement by the conscious starving of the system for resources.

This “enhanced restraint” also will make it difficult if not impossible to well serve all disabled veterans who depend on the VA system as their primary health care provider. Let it be clearly said: “enhanced restraint” means budget cuts.

We have seen this coming for a while, in VA’s long-term strategic planning documents and, most recently in, a February 7th press release from the Department of Veterans Affairs that attempted to put a rosy spin on the \$70.8 billion budget request for that agency’s operations. No fewer than five times is it noted that the department “will be able to care for those veterans who count on VA the most.” This makes a presumption that the veterans who will be pushed out of the system have other options for health care. Many do not. Therefore, they will do without medical care until they get so sick that they lose their jobs, and become destitute and therefore eligible for care. For those who are service-connected disabled, but excluded for the moment, they will be denied medical care until such time as their service-connected condition worsens to the point that they become service-disabled compensable. This does a distinct disservice to veterans. It also means that when, after much delay and worsening of their medical condition, these veterans are granted medical care from VA to which they were statutorily eligible, their need for clinical resources will likely be greater and therefore more expensive than it would have been if they had been granted access to VA health care at an earlier point.

This is not only wrong, but it is fiscally foolish in the medium and long run. It is also a blatant attempt to circumvent the law and the will of the American people to care for veterans.

We challenge the new Secretary of Veterans Affairs, the bureaucrats at the Office of Management and Budget (OMB) who are in large measure responsible for this document, and all concerned to cite anywhere in statute where it says that the VA will only serve a “core constituency” of “veterans who count on VA the most.” Indeed, if it is the will of the people to narrow the parameters of eligibility for VA services, then one would hope you will be open, honest, and forthright in this matter and move to amend the law. But do not penalize veterans in a backdoor machination.

VVA has said this before and we’ll say it again: The cost of caring for those who have borne the battle, and their widow and their orphans – this quote adorns the side of the VA headquarters on Vermont Avenue – is part of the cost of the national defense. It is up to you, the members of Congress who must agree on what programs and services are to take precedence in funding, to consider this – and honor this – as you deliberate the administration’s budget proposal. Caring for veterans is not a Democratic cause. It is not a Republican effort. It is an *American* issue, one that cuts across all party affiliations.

VVA has in the past, and does today, Mr. Chairman, call for action for much greater accountability from all elements of the VA. From Veterans Health Administration (VHA) there must be much greater accountability for clinical outcomes, overall management of resources, and securing the best possible use of the taxpayer dollars to secure the best possible health care for our nation's veterans. That means greater scrutiny of all contracts, of part time physicians, of so-called "enhanced use" lease deals that may be in fact be "sweetheart" deals, a hard look at bonuses at every level, and comprehensive and close scrutiny of high ranking doctors, nurses, and other clinicians who see few or no patients at the same time that it is difficult to secure enough coverage for inpatient wards.

We hope that you will work with us on this vital issue of accountability, as well as the effort to ensure that VHA moves more quickly toward truly becoming a "*veterans* health care system" and not one that is all too often general health care that happens to be for veterans. To VVA, that means that a complete military history must be taken and used for each veteran in the VHA system, to get the most complete diagnosis and medical treatment plan possible.

VVA also hope to work closely with you to achieve more proper observance of veterans preference in hiring by all parts of VA, and ensuring that VA exceeds the goal set in law, and re-emphasized by President Bush in Executive Order 13-360 to exceed securing at least 3% of all goods and services from service-disabled veteran-owned businesses. Part of real accountability is holding VA managers strictly accountable in regard to these two federal laws, which affect the economic well being of veterans.

VVA has certain very specific concerns about the budget request for FY'06. We outline them for you now.

- Our main concern revolves around the effects of this flat-line budget. The effect on a system already operating on the margin of safety in medical and acute care units will now be strained all the more by the "hard freeze" on hiring already implemented at most VA medical centers. Specialized services, such as prosthetics, spinal cord injury, and mental health will be strained to the point of delays or denials of service.
- If passed, this budget will eventuate in a decrease of 1,110,416 veterans from the VA health care system. It says so on page 2-16 of the medical programs budget submission. This is not right. This usurps the covenant between the American people and those who in uniform defended the Constitution.
- The \$250 "user fee," if passed, will force the exodus of veterans who cannot afford this fee. The VA estimates that some 213,000 currently enrolled veterans will opt not to pay this fee to the detriment of their health nor will they opt not to pay the increased drug co-payment of \$15 as proposed by the administration.

Congress rejected these misguided proposals last year. We hope you will do the same this time around.

- The budget cites an anticipated savings of some \$590 million in unnamed “management efficiencies.” Does this mean laying off half of the staff at VA’s headquarters? Deferring yet more needed preventive maintenance and capital improvements? More important, what exactly will this mean as it trickles down to individual VA medical centers? We fear that this will lead to longer waits to be seen by primary care physicians and by specialists, and a general degradation of the system.
- At the same time, the proposed budget does not take into account long-term care. Nor does it consider the short-term or long-term needs of a new generation fighting today in hotspots around the globe. Many of these men and women are returning to our shores with grievous, maiming injuries that will take years of treatment and rehabilitation.
- With regard to long-term care facilities, an increasing need will be met by decreasing resources. The \$312 million slash in funding for nursing homes (including care for veterans in state extended care facilities) will result, according to top VA officials, in some 5,000 fewer beds in the VA system. This will impact the states, and on the families of veterans who urgently need this care. What will they do?
- There are no additional resources provided for the VA Readjustment Counseling Service, or vet center program. This is the most studied program of the VA, and every study, by GAO and others, have found that this is the most cost-effective, cost-efficient program operated by the VA. An investment of \$17 million in the vet centers would by one full-time family counselor skilled in grief counseling and PTSD counseling in each of the 206 centers, as well as an additional 40 staff to augment the staff at centers near clusters of the returning veteran population to be able to meet their needs. Vet Centers help keep veterans employed, and help keep their families together. This \$17 million would disappear into the rest of VHA without a trace, whereas by setting aside this amount for an increase in the vet centers budget will have an immediate, measurable, and very visible impact.
- The budget proposal flat-lines funding for medical research, which we believe is a mistake. The National Institutes for Health received a significant increase yet once again, despite the fact that it does not fund even one veteran-specific grant. Are veterans less worthy, or their health care needs not worth studying? It is only through research that we gain knowledge that we then turn into practical applications of immediate benefit to improve care for veterans, especially as to conditions that may have originated in military service. Of course, these discoveries not only accrue to veterans but to all of us. The VA can be justifiably

proud of the fruits of its research over the past half-century; one researcher was awarded a Nobel Prize for her research. This cannot continue without proper funding.

- When the endorsement of the CARES program by former Secretary Principi was announced, we were assured, in a presentation at the Longworth House Office Building, that this initiative would be funded to the tune of \$1 billion a year over the next five years. This was guaranteed. Now we see funding of \$750 million. This might be the silver lining in an otherwise grim budget: The VA is forced to rework what we see as a flawed formula on which the CARES model is based. Most veterans are not middle class. They present at VAMCs with far greater frequency than do most middle-class health consumers, a salient fact not taken into account by CARES. Currently CARES *still* does not take into account long-term care, nor does it take into account returning veterans who are disabled, wounded, and ill from the war raging in Iraq, Afghanistan, and elsewhere in the world.

Mr. Chairman, as you are aware there are more than 250,000 homeless veterans sleeping on the streets or in shelters every night. While we appreciate the slight increase in the VA FY06 budget for homeless programs, VVA believes that the VA Health Care for Homeless Veterans funds, which includes the Homeless Grant and Per Diem Program, needs to be a separate line item in the budget. For these veterans, who once served our nation with pride, we simply must do more and we must do better.

In regard to the Veterans Benefits Administration, (VBA), VVA is concerned that the structural shortfall of resources in funding is not addressed in this budget. As you are aware, \$125 million had to be transferred from medical care services this year just to keep a minimum number of staff, particularly compensation and pension adjudicators, on the job and working in order not to fall even further behind in the time it takes to get a fair and accurate decision on a veteran's claim. We are also concerned that there does not appear to be any significant enhancement in the number of veteran benefits counselors to assist returning OIF/OEF veterans who may need their assistance, nor does there appear to be any major outreach campaign to reach returning veterans, as well as returning members of the National Guard and Reserves.

Many members of this committee are familiar with a quote from the father of our country, George Washington: "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their nation." As you discuss and debate this budget, think about this, and those in uniform in Iraq and Afghanistan.

Vietnam Veterans of America

Statement for the Record
VA FY06 Budget
February 16, 2005

Mr. Chairman, Vietnam Veterans of America thanks you and your distinguished colleagues for considering our views on this issue of vital importance to veterans of every generation.



Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

VIETNAM VETERANS OF AMERICA

Funding Statement

February 16, 2005

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

Director of Government Relations
 Vietnam Veterans of America.
 (301) 585-4000, extension 127

STATEMENT OF

MARK H. OLANOFF, Command CMSgt, USAF (Ret)

Executive Director, Washington, D.C., Office Of

THE RETIRED ENLISTED ASSOCIATION

Before a

HEARING

Of the

HOUSE VETERANS AFFAIRS COMMITTEE

FY 2006 VA Budget

On

February 16, 2005

Biography of Mark H. Olanoff, Command Chief Master Sergeant, USAF (Ret)

Executive Director, Washington Office, The Retired Enlisted Association

Command CMSgt Mark H. Olanoff enlisted in the U.S. Air Force on September 27, 1967 after graduating from Darby Township High School in Glenolden, Pa. After completion of basic military training and technical training he was assigned to Osan AB, Korea in 1968 working in the military personnel division. Chief Olanoff served in numerous military personnel assignments at Othello AFS, Washington; RAF Bentwaters, England and Griffiss AFB, NY. He was discharged from the U.S. Air Force on July 30, 1976 and joined the New Jersey Air National Guard in Atlantic City, New Jersey serving in positions of Non-Commissioned Officer in Charge (NCOIC), Customer Assistance; NCOIC, Consolidated Base Personnel Office and Chief, Personnel Systems Management. Chief Olanoff transferred to the Air Force Reserve at Dover AFB, Delaware on June 19, 1989 serving as Chief, Personnel Systems Management until Feb 9, 1991. Chief Olanoff assumed the position of Chief, Personnel Systems Management for the 436th Airlift Wing (as a federal civil servant) from Feb 10, 1992 until May 22, 1993.

On April 1, 1992, Chief Olanoff assumed the position as the Senior Enlisted Advisor to the Commander of the 512th Airlift Wing, Dover AFB, DE. In this position, Chief Olanoff served as the Commander's representative on all enlisted issues. During his tenure in this position, Chief Olanoff was TDY to the Persian Gulf. He served in this position until his retirement from the Air Force Reserve on June 10, 1996.

On April 1, 1996, Chief Olanoff assumed the position of Veterans Service Officer for the State of Delaware assisting veterans with Veterans Affairs (VA) claims and representing the Commission of Veterans' Affairs at many meetings and functions. He was appointed to the VA Veterans Integrated Service Network (VISN) 4 Management Advisory Committee, which includes the areas of Pennsylvania, Delaware, parts of South New Jersey and parts of West Virginia.

Chief Olanoff assumed his current position as Executive Director, Washington Office on October 25, 2004 after previously serving as TREA's National Legislative Director from December 1996 until March 2002. He then served as The American Legion's Assistant Legislative Director and Deputy Legislative Director from April 2002 until October 2004. He served as Co-Director of the National Military Veterans Alliance, representing 31 military and veterans' organizations. He also served as Co-Chair of the Retirement and Veterans Affairs Committees for The Military Coalition (TMC). He also served as a member of the Guard and Reserve Committee of TMC, and as a member of the Legislative Affairs Committee for the Alexandria, Virginia Chamber of Commerce. Further, he served as Vice Chair of the Government Relations and Public Affairs Council for the Greater Washington Society of Association Executives (GWSAE) and previously served as Chair of the Federal Subcommittee of the council and served on a task force to create GWSAE-PAC. Also served as a member of the Department of Veterans' Affairs Health eVet Steering Committee, which worked on a computerized medical record for veterans'. He currently serves on TMC's Awards Committee, Retirement Committee and the American Society for Association Executives Greater Washington Public Policy Committee.

He holds an Associate in Applied Science from the Community College of the Air Force in Human Resource Management (April 1980) and a Bachelor of Arts in Political Science from Stockton State College, Pomona, New Jersey (May 1986). He has completed 9 semester hours at the Graduate level in Legislative Affairs from George Washington University.

Chief Olanoff is a graduate of the 8th Air Force Leadership School at Barksdale AFB, LA and a distinguished graduate of the Air National Guard NCO Academy at the Professional Military Educational Center in Knoxville, Tennessee. Chief Olanoff's military awards include the Meritorious Service Medal with one oak leaf cluster, the Air Force Commendation Medal with two oak leaf clusters, the Air Force Achievement Medal with one oak leaf cluster, the Armed Forces Expeditionary Medal, the National Defense Service Medal with one service star, the Southwest Asia Service Medal with one service star, the Korea Defense Medal and the Kuwait Liberation Medal. Chief Olanoff has been awarded the Master Personnel Badge.

Chief Olanoff is married to the former Dorothy Venanzi and lives in Reisterstown, Maryland.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Retired Enlisted Association does not currently receive, has not received during the current fiscal year or either of the two previous years any federal money for grants or contracts. All the Association's activities and services are accomplished completely free of any federal funding.

Mr. Chairman: It is an honor for The Retired Enlisted Association to submit a Statement for the Record about our concerns for American veterans' before your Committee.

The Retired Enlisted Association is a Veterans' Service Organization founded 42 years ago to represent the needs and points of view of enlisted men and women who have dedicated their careers to serving in all the branches of the United States Armed Services active duty, National Guard and Reserves, as well as the members who are doing so today.

We are here today while hundreds of thousand of enlisted men and women are serving in war zones all across the world. We all share an admiration and loyalty for these dedicated and brave men and women and a duty to protect and serve them. What we all can do is join together to make sure that when they return to their home, America, they obtain the best health care and other benefits that they have been promised. And for those who we have lost we must provide for the love ones they have left behind.

VA HEALTH CARE

It is of course well known to all of you that VA health care is not adequately funded. Furthermore this figure includes \$2.6 billion that is proposed to come from third party insurance payments and increased co-pays from veterans. The Administration proposes both a \$250 yearly enrollment fees for veterans enrolled in Categories 7 and 8 and an increase from \$7 to \$15 for these same veterans for their prescription co-pays. TREA strongly opposes both proposals. These increases are burdensome and unwise.

We oppose the enrollment fees for two reasons. First, there is no guarantee of health care for those in Categories 7 and 8. To charge veterans an enrollment fee but with no guarantee that they will receive health care is simply wrong. Veterans deserve better treatment than that. It amounts to nothing more than trying to balance the VA budget on the backs of those who have served their country in uniform.

Second, it is our strong belief that veterans who already pay premiums or enrollment fees for a health care plan should not be charged a fee to enroll in VA health care. By definition, veterans in Categories 7 and 8 have their own health insurance, for which they pay a monthly premium, already enrolled in TRICARE, or they pay the Medicare Part B premium. Either way, they have already paid for health care. The Department of Veterans Affairs currently collects from third party insurance as payment for the services they provided to veterans with private health insurance. It is our position that VA should also have the right to collect from Medicare as the third party insurer for those veterans who are enrolled in Medicare.

We recognize this committee does not have primary jurisdiction over this issue, but nonetheless, we strongly advocate for Medicare reimbursement to the Department of Veterans Affairs.

With regard to the increase in prescription drug co-pays, while an increase of \$8 a prescription may seem small at first glance but most of these beneficiaries do not take a single pill a day -- they take 5 or 10. This increase alone can mean an increase of \$80 to \$100 a month for a veteran. We know that the cost of drugs is worrisome issue for retirees and seniors throughout our nation. We are grateful that the President is proposing to end all co-payments for former POW's and those in hospice care. We should not fail to mention how pleased we are that the President's proposal includes allowing the VA to pay for emergency and urgent care for enrolled veterans in non VA facilities. Both proposals will facilitate obtaining care at crucial and difficult times in a Veteran's life. Additional money is also needed to provide the promised 2 year VA medical care to all veterans returning from Iraq and Afghanistan. We don't know what that benefit will end up costing (because we don't know how it will work and how many returning Vets will take advantage of it). But we do know that it is crucial at this time in our Nation's history that we both keep all the promises that we make to veterans and that we are seen keeping the promises.

Effective and sufficient VA Health care is crucial to all Veterans including Military Retirees. In Categories 1-3 (service disability qualification) 30% of all enrollees are Military Retirees (as of September 30, 2003: 606,234 out of 2,030,111). In total 890,072 of the approximately 7,000,000 present VA enrollees are Military Retirees. It is a very important benefit for our members. Retirees especially need to take advantage of the areas of expertise that the VA has developed. Approximately 2/3 of the Retiree enrollees are service connected disabled.

The Retired Enlisted Association believes that all military retirees without service-connected disabilities, as well as those disability classifications lower than Category 3,

should be put in Category 3 with other special veterans, such as Purple Heart recipients and ex-POWs. Along with veterans with service-connected disabilities and indigent veterans, military retirees were promised a health care benefit for the rest of their lives. If a military retiree lives in an area where there is no access to the DoD health care system, that retiree should have access to VA health care that is guaranteed. Such is not the case for those now enrolled in Categories 7 or 8.

In addition, we advocate that those veterans who have a service-connected disability rating of 0 percent also be put in Category 3. Currently, those veterans cannot enroll in the VA health care system if they are not already enrolled. However, those with a rating of 0 percent are classified as disabled veterans. Under the proposed legislation, those not currently enrolled would be forced to pay an enrollment fee for something to which they are entitled.

The problem of inadequate funding is a structural problem that must be corrected in a systematic way. While adequate funding for this year is crucial we are well aware that you are the Authorization Committee not the Appropriation Committee. But this problem of insufficient funding is not going to go away in a year. This Committee can move forward to systematically correct this problem by making the funding for VA Health Care guaranteed. For the last several years the problem has been the same. It is not any individual year's budget that is the problem; it is method of funding itself. What is really necessary is guaranteed funding. That is something that only Congress can do.

TREA urges Congress to reject the proposed increases in drug co-pays and the proposed \$250 yearly user fee for Categories 7 and 8 enrollees. TREA also urges Congress to adopt guaranteed funding for all enrolled VA beneficiaries.

VETERANS EDUCATION BENEFITS

Health care and educational benefits are the two VA benefits that all returning Veterans are expecting and relying upon. TREA'S goal (along with the other members of the Partnership for Veterans Education Taskforce) has been to have the Montgomery GI Bill cover the average costs of a four year public University education. Thanks to the Committee, Montgomery GI Bill's benefits have moved substantially higher. On October 1, 2003 the benefits rose to \$985 a month. When the increases were planned this amount would have covered 68% of the average costs of a Public University's four year degree. However, in the last year there have huge increases in tuition and fees in many states across the country. \$985 a month, while a terrific improvement from just a few years ago will not come close to even the 68% of the average education costs it was expected to cover. For newly returned veterans this is the benefit that can help him or her move back successfully into the civilian world. It is vital that the MGIB rate reflect what it really costs to get a college degree. We reiterate that the monthly benefits should be determined by the costs of a 4 year public university degree. If the monthly benefit was statutorily determined in this method then Congress would not be repeatedly forced to play catch up when the dramatically rising costs of higher education gut the benefit Congress means the service members to have. Having this guarantee would reassure the service member that

his or her benefit will not lose its value while he or she continues to serve. It should make them feel more comfortable about reenlisting. And of course it is crucial that we do everything possible to encourage recruitment and retention during this critical time.

TREA also hopes that Congress will consider changing the National Guard and Reserve's benefit package. The new burdens that are being placed on the Guard and Reserve at this time and for the foreseeable future affect their civilian careers as well as the rest of their lives. It is no longer 2 days a month and 2 weeks in the summer. Now a Guard member or Reservist can expect to be called up for at least 1 year in every 5. And many Reservists will be called up much more often. This will clearly affect their future civilian careers. They should have an educational benefit that will help them adapt to a changing employment world. It is only fair. When the Reserve Montgomery GI Bill was created it was intended to provide 47% of the Active Duty Montgomery GI Bill. But the Reserve Bill has not kept up. Since the last increase in the MGIB took effect on October 1, 2003, the Reserve's MGIB is only 27% of Active Duty's MGIB. (\$276 a month compared to \$985 a month) This has happened at a time when the Guard and Reserve is being asked to do more and more. Last Congress, Senator Zell Miller of Georgia introduced 2 bills that would greatly improve the present situation. S 2100 would return the Reserves' educational payments to 47% of the Active Duty rates in four steps going through fiscal year 2007. The Senator's second bill, S2099 would modify the eligibility benefits of the Montgomery GI Bill to allow those who serve at least 2 active duty years in a continuous period of 5 years to qualify for the program. At the present time a Service Member needs to serve 2 continuous years of Active Duty to qualify for this benefit. These changes correspond to the changes in the National Guard's and Reserves' duties and obligations. It should be a real help towards retaining Reservists for the future.

TREA would like to suggest one additional improvement in the National Guard and Reserve educational benefit. There should be a change in the delimiting period. At the present time a member has 14 years to use his or her benefit. But the time starts to run as soon as the member enters the Guard and Reserve. Therefore while the member is working at his or her civilian career, and is being called up at the present rate he or she must find the time to go to college or lose the benefit forever. It would be far better if the period would start to run after the member leaves the Guard or Reserve.

TREA suggests that the Active Duty Montgomery G.I Plan's payments be pegged to the cost of a 4 year Public University Degree. TREA further recommends that both SelRes MGIB payments be raised to return to the original 47% of the Active Duty MGIB payment and that members of the Guard and Reserve be allowed to qualify for Active Duty MGIB if they serve an aggregate of at least 24 months in five years.

VA CLAIMS BACKLOG

For years the delays in adjudication of VA claims have been crippling. Often claimants had to wait for years to get an initial decision and then there are further long delays if an appeal is appropriate. Secretary Principi pledged to work on reducing this backlog and indeed the VA has made substantial progress. We should take notice when things are getting better. And this is much better. However, the job is still not done. The VA needs

to continue to hire the most talented professionals that are available and to provide them with sophisticated continuing professional training.

TREA hopes that Congress will continue to monitor the improvement in Claims adjudication.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

When there is a massive plan to close or realign numerous hospitals and facilities that are depended upon by our members we would always be very concerned. TREA is well aware that the goal of the CARES Program is to make the VA more efficient and modern- an unassailable stated goal. However, even in the best of any circumstances such a plan would cause great dislocations and difficulties. Today CARES implementation will cause huge difficulties. In the present proposal TREA is particularly concerned that the CARES Commission did not analysis the VA's future needs in light of its Mental Health and long term health care requirements. The VA is required to provide long term health care (nursing home care) for Veterans with a 70% and over disability or for a veteran whose VA disability is the reason he or she requires nursing home care. With the demographics of today it is clear that this will be a growing focus and job for the VA. They will need the plants and equipment for this new mission. They also need adequate plant, properly placed around the country to deal with residential mental health treatment capabilities. This is again a crucial area that the CARES Commission did not take into account when making its plans. Residential mental health treatment is a critically necessary service for some of our veterans. It is both expensive and difficult to find in the civilian system. The VA can additionally bring the expertise necessary to treat problems for military veterans that most psychiatric hospitals and practitioners do not have. It is a service that should not be shortchanged. By moving ahead with the CARES Commission's recommendations before considering these two areas would be foolhardy. It should be done right the first time.

TREA urges that no additional steps in the CARES process occurs until a full study on the future needs of the VA for long term health care and mental health facilities are studies and incorporated into any future plans.

DOD-VA COLLABORATION

It has been a long term goal of TREA's to have real and seamless medical transition from DOD to the VA. The need of this has become painfully apparent in the last year when combat injured service members are coming home and being transferred from DOD to VA facilities all across the country without adequate preparation and follow up services. DOD and all the services are working to try and improve the handoff to the VA. The continued work on IT integration is part of the answer. Collaboration among DOD, the VA and VSO's is also crucial. Everyone accepts more work is needed. The situation will become even more complicated if the CARES realignments and closings move forward.

TREA hopes your Committees will continue to monitor the progress in this crucial area.

SURVIVORS BENEFITS

TREA knows that the United States as a nation has thousands of new survivors. It is important that we keep our promise to their lost loved one. One thing we can easily do is to attach Survivors' Education Benefits to Title 10 active duty MGIB payments. The widows or widowers and the children of those who have died on our battlefields should have the opportunity to get a four year bachelor degree. If Title 38 benefits were linked to Title 10 benefits this goal could be reached in the future.

TREA is very grateful to the Committees and most especially to Representative Bilirakis for the passage of HR 2297 including the "Give Romance a Chance" provisions. Now a DIC recipient can remarry after reaching the age of 57 without losing his or her DIC payments. This is a huge step forward. But we hope in the near future that Congress will be able to move that provision back to age 55 so it can match CHAMPVA and other federal survivor programs.

TREA urges these Committees to make Title 38 education benefits for survivors' equivalent to Title 10 MGIB benefits and that DIC retention after remarriage will be moved back to age 55.

CONCLUSION

TREA is very grateful for this opportunity to tell you of our members concerns for the future. We are also very aware of the time, energy and dedication all of you expend on Veterans healthcare, education and other benefits. We know that you do not forget those who served. You always remember their sacrifices and needs and those of their families and survivors. And more importantly you act on them. We know what real allies and patriots you are. The members of The Retired Enlisted Association are very grateful.

MATERIAL SUBMITTED FOR THE RECORD



Department of Veterans Affairs
Office of the Chief of Staff

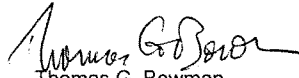
FEB 16 2005

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

Enclosed are the Department of Veterans Affairs' (VA) responses to the pre-hearing questions you submitted in preparation for the House Veterans' Affairs Committee hearing on the VA Budget for Fiscal Year 2006 to be held on February 16, 2005. The Secretary looks forward to working closely with you and other members of the Committee to providing quality benefits and services to our Nation's veterans. The men and women serving in uniform deserve nothing but the best. Should your staff seek additional information, please have them contact Ms. Pam Iovino, Assistant Secretary for Congressional and Legislative Affairs. Ms. Iovino may be reached on 202-273-5611.

Sincerely yours,


Thomas G. Bowman
Deputy

Enclosure

**Questions for the Record
Honorable Lane Evans
Committee on Veterans Affairs
House Veterans Affairs Committee**

Pre-Hearing Questions on the VA Budget for Fiscal Year 2006

Question 1: Please provide for each fiscal year 2001 through 2004 for each regional office, the number of claims processed in each year for each separate program: compensation (provide separate data concerning the number of claims involving 8 or more issues and 7 issues or less), dependency and indemnity compensation (DIC), disability pension, pension based upon age and death pension.

Response: VA data systems do not distinguish between pension based on disability and pension based on age, so we are unable to provide that information. The other information you have requested is contained in Attachment A.

Question 2: Please provide for each regional office and the Appeals Management Center the number of remanded appeals pending, the date each pending appeal was filed and the date of each remand by the Board of Veterans Appeals.

Response: See Attachment B

Question 3: Please provide the timeliness and accuracy goals for each regional office for fiscal years 2001 through 2005. Please describe the methodology used to establish and adjust these goals.

Response: The national targets for accuracy in the Compensation and Pension business line are the same for each regional office in a given year. These targets are formulated based on past performance as well as the strategic goals of the organization. For FY2005 the accuracy targets are now reported separately

<u>Accuracy Goals</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u>	<u>FY 04</u>	<u>FY 05</u>
Rating Accuracy	72%	85%	88%	90%	Comp: 88% Pensions: 93%
Authorization Accuracy	62%	63%	82%	87%	Comp: 92% Pensions: 84%

To determine the timeliness goals for each regional office, the overall national targets are considered, as well as the station's performance in these indicators the previous fiscal year. A calculation is made to determine how much each station would need to improve in order for VBA to meet its national goal. Stations farthest away from the national target are asked to make the largest improvements in timeliness. (Please see Attachment C for specific regional office targets.) Regional office specific targets were

not developed for fiscal year 2001, as VBA measured results by Service Delivery Networks. For FY2004 and FY2005 the days pending targets are reported separately.

	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u>	<u>FY 04</u>	<u>FY 05</u>
<u>Timeliness Goals</u>					
Days to Process - Rating	202	208	165	145	145
Days Pending - Rating	220	186	100	Comp: 133 Pensions: 96	Comp: 119 Pensions: 69

Question 4: Please provide information concerning the plan to consolidate claims under the Benefits Delivery at Discharge (BDD) program, including the rationale for the plan, the timeline for consolidation, the increased number of FTEE who will be allocated to the consolidated sites and the number who will be decreased at other regional offices.

Response: VBA is consolidating the rating aspects of the BDD program to the Winston-Salem and Salt Lake City Regional Offices. This will allow those sites to make further improvements in timeliness, quality, and rating consistency. Consolidating the rating function to two sites will also allow for some specialization, resulting in increased capacity to handle BDD claims. The BDD program will be monitored through program integrity reviews and internal controls.

The consolidation will occur in stages at the Winston-Salem and Salt Lake City Regional Offices. Each regional office is now receiving BDD claims from one feeder station to ensure that the process is working efficiently prior to phasing in the remaining BDD workload. The phased transfer of all BDD claims workload is scheduled to be completed by March 2006. A total of 120 FTE will be hired for this effort, 65 at the Salt Lake City Regional Office and 55 at the Winston-Salem Regional Office. Hiring and training are currently taking place at both sites and will continue until late Summer 2005. Decreases in RVSR personnel at regional offices no longer rating BDD claims will occur through normal attrition rates and those FTE will not be replaced.

Question 5: Please provide the methodology and rationale for allocating resources to regional offices and the Appeals Management Center, including the number of claims which were referred to the AMC in FY 2004 and the number of months, the claims were in remand status.

Response: Over the last few years, VBA has utilized a performance-based resource allocation methodology. Regional offices are evaluated in terms of their weighted share of workload receipts and their ability to meet and/or exceed operational performance indicators in accuracy, timeliness, appeals resolution, and appeals timeliness. By linking the resource allocation process to strategic performance measures, VBA is reinforcing its commitment to the organizational mission.

The initial staffing at the Appeals Management Center (AMC) of 81 employees was based primarily on a projected incoming workload of 14,400 remands per year. Consideration was also given to the pending workload at the Board of Veterans' Appeals (BVA) Development Team. Based on the actual receipt of 24,000 remands in fiscal year 2004, AMC staffing was increased to the present level of 87 employees. Additionally, VBA has supplemented the AMC by utilizing resources from other regional offices to assist with the remand workload.

In response to question 2, information was provided on each pending remand, including the date each appeal was filed, and the date each was remanded by BVA. The average number of days in remand status for those remands currently at the AMC is 294 days.

Question 6: Please provide the current status of each completed and pending Training and Performance Support Systems (TPSS) module, including costs for this program in fiscal years 2002, 2003, 2004 and anticipated for 2005. Describe current plans including target dates and cost for making each TPSS available on line.

Response:

1. The following TPSS modules (and Electronic Performance Support System, or EPSS) have been completed and released to the field since inception of TPSS:
 - A. C&P:
 1. Modules:
 - (a) RVSR Modules:
 - (1) Prerequisite Training Module
 - (2) Original Compensation, v.4.0
 - (3) Original Pension, v. 4.0
 - (4) Original DIC, v. 4.0
 - (5) Reopened Compensation--classroom
 - (6) New Pension--classroom
 - (7) Reopened DIC--classroom
 - (8) Routine Future Examination, v. 4.0
 - (9) Hospitalization/Convalescence, v. 4.0
 - (10) Ancillary Benefits
 - (11) Due Process, v.2.0
 - (12) Medical Terminology
 - (13) Musculoskeletal System
 - (14) Special Monthly Compensation
 - (15) Reopened Compensation—major revision/conversion to web
 - (16) New Pension—major revision/conversion to web
 - (17) Reopened DIC—major revision/conversion to web
 - (b) VSR Modules:
 - (1) Original Claim for Compensation, v. 2.0
 - (2) Dependency Benefits, v. 2.0
 - (3) Original Claim for Pension, v. 2.0

- (4) Income Adjustments, v. 2.0
- (5) Death Pension, v. 2.0
- (6) Burial Benefits
- (7) DIC Spouse/Child/Parent
- (8) Accrued Benefits
- (9) Apportionment Benefits
- (10) Special Monthly Pension
- (c) Appeals:
 - Certify a Claim to the Board of Veterans Appeals
- 2. EPSS and Job Aids:
 - (a) EPSS
 - (1) Medical EPSS, v. 3.0 (RVSR)
 - (2) CHAMPVA (VSR)
 - (3) Hospital Adjustments (VSR)
 - (4) Character of Discharge (VSR)
 - (5) Dependents Educational Assistance (VSR)
 - (6) Effective Dates (VSR)
 - (7) Incompetency (VSR)
 - (8) Helpless Child (VSR)
 - (9) Income/Net Worth Determination (VSR)
 - (10) Accrued Benefits (RVSR)
 - (10) Report Generator (Field Examiner)
 - (b) Job Aids
 - (1) Appeals (RVSR)
 - (2) Original Compensation (RVSR), v. 2.0
 - (3) Original Pension (RVSR), v. 2.0
 - (4) Original DIC (RVSR), v. 2.0
 - (5) Reopened Compensation, v. 2 (RVSR)
 - (9) New Pension, v. 2 (RVSR)
 - (6) Reopened DIC, v. 2 (RVSR)
 - (7) Routine Future Examination (RVSR), v. 2.0
 - (8) Hospitalization/Convalescence (RVSR), v. 2.0
 - (9) Due Process (RVSR), v. 2.0
 - (10) VSR Handbook (VSR)
 - (11) Field Exam Report (Field Examiner)
 - (12) Field Exam Beneficiary Interview (Field Examiner)
 - (13) Benefits Job Aid (Field Examiner)
 - (14) Special Monthly Compensation (RVSR)
 - (15) Public Contact (VSR)
 - (16) Special Monthly Pension
- B. Insurance:
 - 1. Module: Reinstatement
 - 2. EPSS and Job Aid Products:
 - a. Dividends
 - b. Posting
 - c. Lapse

- d. Deductions
 - e. Policy Services EPSS User Guide
 - f. Life Cycle Maintenance Tool for Job Aids
 - g. Off Tape Loans
 - h. Waiver of Premiums
 - i. Registers
 - j. Appeals
 - k. VICTARS Reference Tool; VICTARS and ADE
 - l. Death Claims Manual Input
 - m. RH.
- C. Loan Guaranty:
- 1. Web-based Training:
 - a. Credit Standards Course: 11 Lessons.
 - b. Loan Specialist Course: 9 Lessons.
 - c. Specially Adapted Housing Course: 14 lessons
 - d. Specially Adapted Housing Things to Know Module
 - e. Specially Adapted Housing Things to Do Module
 - f. Construction Complaints Course: 4 lessons.
 - g. Appraisal Field Reviewer Course.
 - 2. Job Aids and Tools:
 - a. Credit Standards Help Tool.
 - b. Credit Standards Glossary Tool
 - c. Credit Standards Job Aid
 - d. Loan Specialist Help Tool
 - e. Loan Specialist Glossary Tool
 - f. Specially Adapted Housing Help Tool
 - g. Specially Adapted Housing Glossary Tool
 - h. Specially Adapted Housing Indexed and Searchable Reference Tool
- D. Education:
- Web-based training: Education Claims Course: 7 Modules
2. The status of each pending (in development) TPSS module, EPSS, and job aid is as follows:
- A. C&P: In Development:
- 1. Modules:
 - a. RVSR Modules:
 - (1) Appeals module—estimate fielding by March 2005.
 - (2) PTSD Course: 2 modules—in early development.
 - b. VSR Module: PTSD—1 module—in early development.
 - c. Field Examiner Modules: 6 modules in the Initial Appointment Course. Field in February-March 2005.
 - d. Field Examiner On Line Training Coordinator's Course—Field in February-March 2005.
 - e. Major revision to VSR modules to reflect the Claims Processing Initiative (CPI) will begin in 2005, based on the new VSR CPI task analysis completed in 2004.

2. EPSS and Job Aids:
 - a. RVSR:
 - (1) Appeals Job Aid—estimate fielding by March 2005.
 - (2) PTSD Job Aids—in early development.
 - (3) Effective Dates EPSS—in early development.
 - b. VSR:
 - (1) PTSD EPSS—in early development.
 - (2) Eligibility Verification Report EPSS—in early development.
 - (3) Revisions to VSR EPSS based on the VSR CPI task analysis.
 - c. Field Examiner:
 - 22 Job aids and Knowledge Aids—estimate fielding February-March 2005.
- B. Insurance: In Development:
 1. Modules: 0
 2. EPSS and Job Aids:
 - a. Updated Manual Inputs EPSS—in early development.
 - b. Reinstatement EPSS—in early development.
 - c. Life cycle updates for Insurance products.
- C. Loan Guaranty: Life cycle updates of existing modules and job aids.
3. TPSS costs for 2002, 2003, 2004, and (anticipated) 2005.

Notes: 1. For "costs", the figures below show the amount of total TPSS task order awards for all TPSS activities and products in various business lines by fiscal year, for 2002 through 2004. The figure for 2005 is based on estimated amounts available for TPSS task order awards from Compensation and Pension Service, Insurance Service, and Loan Guaranty Service.

 2. Costs do not include travel funds.

2002: 5,867,224
 2003: 5,490,901
 2004: 2,765,180
 2005: 2,715,000
4. Current plans, including target dates and costs, for making TPSS available on line:

All TPSS and EPSS modules and job aids are already on line, and all new modules and job aids are delivered on line.

Question 7: Please provide a detailed listing, including cost, locations served, and number of individuals contracted to provide Vocational Rehabilitation & Employment (VR&E) services to participating service-connected veterans.

Response: See Attachment D

Question 8: Please provide an update on the Education Service's succession/staffing plan.

Response: Nineteen percent of employees in the Education Program nationwide are eligible for retirement in 2005. This number increases to 29 percent by 2008. To replace these retirees, VBA plans to continue utilizing hiring authorities like the Outstanding Scholar Program and the Veterans Readjustment Act. In addition, VBA has developed a standardized training program for its key positions and is developing recruitment strategies for positions that are traditionally harder to fill or may require relocation.

Question 9: Please provide NCA's strategic plan concerning national cemetery repair and maintenance efforts, including cost estimates.

Response: The National Cemetery Administration (NCA) is using a multi-faceted strategy to address cemetery maintenance and repair needs. The Millennium Act Report to Congress (Volume 2, National Shrine Commitment) provides a comprehensive assessment of the condition of VA's national cemeteries. The report identified the need for 928 repair projects at an estimated cost of \$280 million to ensure a dignified and respectful setting appropriate for each national cemetery. NCA is using the information and data provided in the report to plan and accomplish the repairs needed at each cemetery. Since the report was issued in August 2002, NCA has completed work on 89 projects, and initiated work on additional projects, with an estimated cost of \$77 million.

NCA has also developed new performance metrics that will be used to improve the appearance of its national cemeteries. Baseline data were collected in 2004 for three new performance measures designed to assess the condition of individual gravesites, including the cleanliness and proper alignment of headstones and markers. With this baseline data, NCA has identified the gap between current performance and the strategic goal for each measure.

Approximately one-third of the discretionary budget for burial programs is used for the maintenance of national cemeteries as national shrines. This includes mowing and trimming, routine maintenance as well as repair projects to improve cemetery appearance. The FY 2006 budget requests \$101 million for national cemetery maintenance, including \$20 million for gravesite renovation and infrastructure repairs.

The report includes an extensive database of condition assessment information. This data is used in the planning process to assist in prioritizing repair projects over a multi-year period. NCA evaluates the problem categories and the severity of problems within each category. Data from NCA's Annual Survey of Satisfaction with National Cemeteries is also used to factor in the viewpoint of veterans and their families when determining project priorities.

Repairs to address long-standing deferred maintenance needs are addressed in a variety of ways. Gravesite renovation projects to raise, realign and clean headstones and markers and to repair sunken graves will continue to be a high priority in allocating operational resources. Infrastructure improvements to buildings, roads, irrigation

systems and historic structures are addressed with capital expenditures through the major and minor construction programs. In addition, cemetery staff will be used to complete some repairs.

NCA has also established an Organizational Assessment and Improvement Program to ensure regular and consistent assessment of performance against established standards. Each national cemetery will be evaluated through site visits conducted on a cyclical basis. In addition, NCA will develop and evaluate new innovations and equipment to make the most effective use of resources in meeting cemetery maintenance needs.

Question 10: Please provide data concerning the State Cemetery Grant Program, including the number of grants awarded in fiscal year 2004, total grant amounts, average grant amounts, and award locations.

Response: In FY 2004, VA provided \$33.6 million for grants associated with 8 projects to establish or expand state veterans cemeteries. The average grant award was \$4.2 million. Grant funding was provided at the following locations:

Winfield, Kansas (\$5.8 million, New Cemetery)

Hilo, Hawaii (\$750,000, Cemetery Expansion)

Killeen (Ft. Hood), Texas (\$8 million, New Cemetery)

Boulder City, Nevada (\$1.6 million, Cemetery Expansion)

Redding, California (\$8.5 million, New Cemetery)

Boise, Idaho (\$5 million grant adjustment, New Cemetery)

Hopkinsville (Ft. Campbell), Kentucky (\$250,000 grant adjustment, New Cemetery)

Bear, Delaware (\$3.6 million grant adjustment, Cemetery Expansion)

ATTACHMENT A

ORIGINAL CLAIMS COMPLETED
FY 2001-2004

	EP 110 - DISABILITY COMPENSATION, 1 TO 7 ISSUES				EP 010 - DISABILITY COMPENSATION, 8 OR MORE ISSUES				EP 180 - DISABILITY PENSION				EP 140 - DEATH COMPENSATION/IDIC				EP 190 - DEATH PENSION			
	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004
National	67,677	143,167	156,700	138,182	18,872	29,455	32,881	30,422	29,050	39,553	36,129	32,851	19,898	29,873	32,346	27,191	34,433	42,313	40,491	38,822
Eastern Area																				
Baltimore	970	1,949	2,496	2,130	386	901	761	726	297	364	338	242	239	357	418	323	311	407	420	349
Boston	874	1,242	1,457	1,705	59	60	64	77	343	292	338	410	370	346	362	362	533	469	320	484
Buffalo	1,292	2,319	3,028	2,387	99	186	338	394	410	661	650	539	198	298	371	309	601	1,060	829	768
Cleveland	1,857	3,577	4,536	3,914	184	235	333	386	1,090	1,528	1,566	1,452	539	485	1,274	819	1,500	1,772	1,496	1,485
Detroit	1,074	2,520	3,446	3,526	67	132	181	203	657	873	848	832	412	576	628	610	619	716	670	642
Hartford	300	968	712	757	29	109	102	93	172	339	208	171	73	160	128	107	213	303	382	280
Indianapolis	877	2,090	3,151	3,042	62	92	152	172	488	598	544	507	271	355	336	321	653	810	761	598
Manchester	321	656	596	431	45	80	72	59	86	134	106	126	77	92	90	93	88	121	125	135
New York	775	2,604	2,880	2,365	65	145	189	154	612	812	789	663	269	529	504	484	993	1,334	1,438	1,016
Newark	663	1,568	1,966	1,370	61	96	90	95	273	237	244	140	272	278	394	216	528	683	609	443
Philadelphia	1,719	2,735	2,942	3,128	165	257	318	299	665	840	767	834	427	668	1,213	1,553	832	855	836	858
Pittsburgh	689	1,676	1,345	1,510	67	127	100	203	706	996	942	767	210	192	437	362	789	1,221	1,057	1,082
Providence	147	707	599	809	27	95	63	70	107	157	129	126	111	165	146	165	273	236	181	170
Spurs River Jet	374	1,042	997	1,001	57	135	144	160	174	288	203	186	117	160	159	137	143	214	173	163
Wilmington	138	471	466	371	8	13	17	35	36	71	79	72	45	61	65	77	56	53	114	70
Southern Area																				
Atlanta	3,983	4,318	5,142	4,938	788	1,357	1,197	1,009	1,113	1,369	1,456	1,273	664	833	985	844	1,408	1,842	2,058	2,162
Columbia	1,985	3,020	3,201	2,941	470	539	676	570	713	951	981	874	363	438	503	529	838	1,018	1,173	1,273
Huntington	380	1,505	1,550	1,133	25	57	108	93	289	500	338	287	184	333	254	235	258	419	268	373
Jackson	731	1,849	1,808	1,553	97	256	255	258	689	799	709	567	354	590	450	451	838	1,061	901	856
Louisville	957	2,694	3,319	3,064	373	714	537	943	453	634	533	532	273	460	568	454	690	774	594	857
Montgomery	1,487	2,963	3,259	2,547	312	408	633	477	1,273	1,632	1,592	1,555	644	893	796	733	1,616	1,887	2,354	2,342
Nashville	2,279	3,966	3,576	4,048	502	772	746	878	766	1,098	977	992	590	936	839	790	1,136	1,307	1,281	1,409
Reno	1,963	4,184	4,953	3,713	1,170	2,458	2,970	2,693	446	568	485	473	490	867	860	681	570	1,001	913	1,154
Rochester	183	755	728	675	18	81	100	44	665	778	759	422	162	250	203	202	919	809	982	890
San Juan	5,249	10,648	9,654	8,934	2,158	2,375	2,802	2,409	2,017	3,350	2,953	2,848	1,381	2,458	2,132	2,019	1,748	2,497	2,352	2,321
St. Petersburg	814	934	1,067	423	259	341	710	561	91	66	50	40	292	274	162	45	238	180	96	36
Washington	3,856	6,784	7,140	6,425	1,551	2,370	2,270	2,215	1,122	1,598	1,256	1,238	769	1,298	1,169	1,011	1,316	1,395	1,897	1,336

ORIGINAL CLAIMS COMPLETED
FY 2001-2004

	EP 110 -- DISABILITY COMPENSATION, 1 TO 7 ISSUES				EP 010 -- DISABILITY COMPENSATION, 8 OR MORE ISSUES				EP 180 -- DISABILITY PENSION				EP 140 - DEATH COMPENSATION/IDIC				EP 190 - DEATH PENSION			
	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004	FY2001	FY2002	FY2003	FY2004
National	67,677	143,467	156,700	139,182	18,872	29,455	32,881	30,822	29,050	39,553	36,728	32,851	19,898	29,973	32,346	27,191	34,433	42,313	40,491	35,222
Central Area																				
Chicago	1,942	4,013	3,494	3,060	263	504	456	574	971	1,044	905	825	357	482	429	365	1,337	1,462	1,285	631
Des Moines	435	849	1,334	1,185	30	90	99	86	468	577	565	522	114	167	199	185	523	555	585	850
Fargo	301	718	965	885	53	89	102	118	185	225	205	195	82	100	110	105	187	288	197	1,514
Houston	2,708	5,204	5,710	4,230	1,351	1,673	2,112	1,695	1,198	1,453	1,428	1,046	830	1,021	1,176	1,176	1,871	1,881	1,724	1,914
Indianapolis	913	1,634	2,109	2,120	212	343	376	343	248	340	313	281	134	203	176	157	281	266	204	190
Little Rock	637	1,328	2,555	2,483	263	364	376	343	248	340	313	281	134	203	176	157	281	266	204	190
Madison	1,399	3,450	3,185	3,435	454	721	845	895	532	860	685	704	461	860	722	717	708	481	906	651
Memphis	1,141	2,954	2,716	2,235	216	356	406	353	805	1,128	1,014	819	399	519	572	475	1,086	1,260	1,072	965
New Orleans	1,141	2,954	2,716	2,235	216	356	406	353	805	1,128	1,014	819	399	519	572	475	1,086	1,260	1,072	965
St. Paul	1,217	550	565	590	57	44	80	56	153	190	157	183	75	84	93	72	173	222	190	170
St. Louis	3,194	3,186	3,946	4,265	597	522	487	534	667	1,154	957	945	361	618	504	475	1,582	1,043	1,043	1,096
St. Paul	772	2,115	2,708	3,221	68	83	119	114	453	535	618	482	215	299	336	297	540	707	754	653
Waco	4,382	8,281	7,953	7,245	1,039	1,738	1,730	1,771	1,062	1,513	1,699	1,518	978	1,405	1,838	1,426	1,333	1,817	1,981	1,775
Wichita	521	1,164	1,787	1,212	91	171	232	186	335	423	434	323	140	186	304	216	181	381	421	474
Western Area																				
Albuquerque	522	1,323	1,635	1,242	117	195	275	256	184	201	205	196	211	267	318	240	205	270	168	207
Anchorage	441	661	673	504	166	283	359	247	37	34	34	40	46	58	62	42	11	26	27	20
Boise	1,417	980	794	815	140	190	145	155	246	171	169	101	143	134	124	160	206	135	130	130
Denver	1,482	2,635	2,983	2,110	829	1,116	1,334	1,038	355	544	484	510	394	598	380	388	951	524	467	426
El Harrison	377	656	785	728	59	120	116	115	135	183	138	156	89	79	119	84	152	142	139	118
Honolulu	631	1,311	1,160	1,222	160	333	195	246	55	51	60	56	126	116	214	211	55	25	34	59
Los Angeles	1,631	4,523	5,179	3,351	172	488	572	464	585	905	781	720	506	854	743	573	649	837	657	653
Manila	538	1,162	848	679	24	111	146	56	406	582	407	409	1,047	3,230	3,062	1,933	417	450	312	334
Oakland	2,108	5,078	6,512	5,388	397	781	572	508	529	953	742	706	612	764	1,162	844	714	544	370	327
Phoenix	468	2,631	2,312	2,395	64	321	278	267	550	613	601	582	202	260	271	612	617	512	170	163
Portland	1,108	2,448	3,070	2,705	454	553	632	695	722	977	980	848	568	719	612	844	617	512	170	163
Reno	468	2,631	2,312	2,395	64	321	278	267	550	613	601	582	202	260	271	612	617	512	170	163
San Diego	2,860	5,363	5,823	4,893	1,028	1,433	1,368	1,283	732	1,068	933	864	50	108	125	265	269	220	369	264
San Francisco	2,860	5,363	5,823	4,893	1,028	1,433	1,368	1,283	732	1,068	933	864	50	108	125	265	269	220	369	264
Seattle	2,185	4,788	5,109	3,884	1,355	1,656	1,639	1,538	526	717	618	405	552	830	784	844	432	651	541	633

Vocational Rehabilitation and Employment Service
Listing of Contractor Expenditures for FY 2004
February 1, 2005

Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
A G ELLINGSON PHD	2504	\$4,515.00			341 Salt Lake City
A P JACKSON	2504	\$4,500.00			341 Salt Lake City
AASTUM VOCATIONAL SVCS INC	2504	\$10,575.00			347 Boise
AASTUM VOCATIONAL SVCS INC	2505		\$500.00		347 Boise
ABILITIES INC	2504	\$5,200.00			306 New York
ABILITIES INC	2505		\$14,250.00		306 New York
ABILITIES INC	2506			\$250.00	306 New York
ACCESS CASE MGMT SERVICES	2504	\$65,381.00			316 Atlanta
ACCESS CASE MGMT SERVICES	2506			\$286.00	316 Atlanta
ACTION REHAB	2504	\$2,460.00			345 Phoenix
ACTION REHAB	2505		\$19,810.00		345 Phoenix
ALARIS GRP INC	2504	\$49,950.00			437 Fargo
ALASKA VOCATIONAL & COUNSELING	2504	\$1,200.00			463 Anchorage
ALLIED COMMUNITY RESOURCES INC	2504	\$6,375.00			301 Boston
ALTERNATIVE CAREERS	2505		\$3,500.00		343 Oakland
AMANDA M THIENEMAN	2504	\$100.00			327 Louisville
ANFUSO VACATIONAL SVCS INC	2504	\$81,090.00			344 Los Angeles
ASSOCIATED THERAPEUTICS INC	2505		\$1,563.51		320 Nashville
B M PRESTONBACK	2504	\$12,000.00			321 New Orleans
BARBEE & ASSOCS	2505		\$18,450.00		362 Houston
BEST VOCATIONAL CONS INC	2504	\$28,540.00			339 Denver
BEST VOCATIONAL CONS INC	2505		\$60,934.00		339 Denver
BEST VOCATIONAL CONS INC	2506			\$166.00	339 Denver
BLACK HILLS SPECIAL SERVICES	2504	\$58,405.00			438 Sioux Falls
BRUCE W COLEMAN	2505		\$1,950.00		343 Oakland
C DAMICO	2504	\$1,050.00			318 Winston-Salem
C E M	2504	\$3,905.00			344 Los Angeles
C E PHIPPS	2504	\$60,809.30			314 Roanoke
C R C SERVICES	2504	\$43,850.00			301 Boston
C R MCARTHUR PHD	2504	\$56,100.00			322 Montgomery
C S VOCATIONAL CONSULTANTS LTD	2504	\$36,400.00			334 Lincoln
C VET INC	2504	\$22,207.00			321 New Orleans
CAIRNS COUNSELING CENTER	2504	\$885.00			377 San Diego
CAPABILITIES FOR LIVING LLC	2504	\$1,000.00			320 Nashville
CAPABILITIES FOR LIVING LLC	2505		\$1,586.14		320 Nashville
CAPIELANO & ASSOCS INC	2504	\$1,500.00			321 New Orleans
CAPITOL CITY REHAB GROUP	2504	\$4,964.00			349 Waco
CAPITOL CITY REHAB GROUP	2504	\$49,905.00			351 Muskogee
CAPITOL CITY REHAB GROUP	2505		\$329.00		351 Muskogee
CAPITOL CITY REHAB GROUP	2506			\$2,370.00	349 Waco
CAPITOL CITY REHAB GROUP	2506			\$3,450.00	351 Muskogee
CAREER ACTION ASSOCS PC	2506			\$8,840.00	349 Waco
CAREER DIRECTIONS OF RICHMOND	2504	\$1,500.00			314 Roanoke
CAREER MANAGEMENT SERVICES	2504	\$118,975.00			377 San Diego
CAREER OPTIONS INC	2504	\$52,734.16			314 Roanoke
CAREER OPTIONS INC	2505		\$225,893.57		314 Roanoke
CAREER SERVICES INC	2504	\$103,461.00			377 San Diego

Vocational Rehabilitation and Employment Service
 Listing of Contractor Expenditures for FY 2004
 February 1, 2005

Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
CAREER SERVICES INC	2506			\$265.00	377 San Diego
CASTELLANA & ASSOCIATES INC	2504	\$2,100.00			329 Detroit
CASTLE VOCATIONAL SVCS	2506			\$322.24	347 Boise
CEM	2504	\$27,585.00			344 Los Angeles
CERTIFIED CAREER CONSULTANTS	2504	\$24,611.50			377 San Diego
CERTIFIED VOC EVALUATION SVCS	2504	\$495.00			345 Phoenix
CHARLES G CARLISE	2504	\$680.00			345 Phoenix
CHRIS GEORGEFF & ASSOCS	2505		\$11,025.00		326 Indianapolis
CHRIS GEORGEFF & ASSOCS	2506			\$1,650.00	326 Indianapolis
CHRYSLIS COUNSELING CTR INC	2504	\$5,100.00			339 Denver
CIDDIO MORRIS ASSOCS INC	2504	\$11,254.00			343 Oakland
CIDDIO MORRIS ASSOCS INC	2505		\$3,750.00		343 Oakland
COMM PARTNERSHIP OF IDAHO INC	2504	\$18,050.00			347 Boise
CONCENTRA INTEGRATED SERVICE	2504	\$800.00			323 Jackson
CONCENTRA INTEGRATED SERVICE	2504	\$12,480.00			329 Detroit
CONCENTRA INTEGRATED SERVICE	2506			\$7,516.20	318 Winston-Salem
CONCENTRA INTEGRATED SVCS INC	2504	\$42,000.00			301 Boston
CONCENTRA INTEGRATED SVCS INC	2505		\$68,545.00		317 St. Petersburg
CONCENTRA INTEGRATED SVCS INC	2506			\$420.00	317 St. Petersburg
CONCENTRA MNGD CARE SVCS INC	2504	\$21,750.00			304 Providence
CONCENTRA MNGD CARE SVCS INC	2504	\$45.00			322 Montgomery
CONCENTRA MNGD CARE SVCS INC	2504	\$14,144.00			323 Jackson
CONCENTRA MNGD CARE SVCS INC	2504	\$16,224.00			329 Detroit
CONCENTRA MNGD CARE SVCS INC	2505		\$835.00		322 Montgomery
CONCENTRA MNGD CARE SVCS INC	2506			\$416.01	318 Winston-Salem
CONNECTIONS	2504	\$3,300.00			343 Oakland
CONNECTIONS	2505		\$14,075.00		343 Oakland
CONSULTATIVE REVIEW & REHAB	2506			\$210.00	309 Newark
COREY WOODRING	2505		\$10,300.00		316 Atlanta
CORVEL CORP	2504	\$108,245.00			322 Montgomery
CORVEL CORP	2504	\$18,480.00			316 Atlanta
CORVEL CORP	2505		\$520.00		322 Montgomery
CORVEL CORP	2505		\$880.00		322 Montgomery
CORVEL CORP	2505		\$10,589.00		348 Portland
CORVEL CORP	2505		\$27,125.00		362 Houston
CORVEL CORP	2506			\$195.00	316 Atlanta
CORVEL CORP	2506			\$6,856.53	322 Montgomery
CORVEL HEALTHCARE CORP	2504	\$480.00			316 Atlanta
COUNSELING RESOURCE CTR	2504	\$240.00			327 Louisville
COUNSELING RESOURCE CTR	2505		\$2,904.00		326 Indianapolis
COUNSELING RESOURCE CTR	2505		\$22,420.00		327 Louisville
COURTRIGHT & ASSOCS	2504	\$5,400.00			317 St. Petersburg
COURTRIGHT & ASSOCS	2505		\$2,921.05		317 St. Petersburg
CRAWFORD & CO	2504	\$472.00			321 New Orleans
CRAWFORD & CO	2504	\$19,912.00			346 Seattle
CRAWFORD & CO	2504	\$7,990.00			459 Honolulu
CRAWFORD & CO	2505		\$26,300.00		459 Honolulu

Vocational Rehabilitation and Employment Service
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
D A KING	2504	\$224.00			325 Cleveland
D A KING	2505		\$96.00		325 Cleveland
D J UHLENKOTT & ASSOCS	2504	\$7,850.00			346 Seattle
D W UPCHURCH	2504	\$48,300.00			319 Columbia
DAVID A ZAK	2505		\$35,863.08		311 Pittsburgh
DEMAREST ASSOCS LTD	2504	\$1,360.00			460 Wilmington
DESERT VOCATIONAL SERVICES	2504	\$118,000.00			377 San Diego
DETTMER VOCATIONAL CONS	2504	\$5,500.00			343 Oakland
DETTMER VOCATIONAL CONS	2505		\$13,250.00		343 Oakland
DEVINNEY & DINNEEN CAREER	2504	\$56,853.00			354 Reno
DIANA C SIMS & ASSOCS INC	2505		\$6,930.00		313 Baltimore
DISABILITY ACTION CENTER	2504	\$350.00			319 Columbia
DOUGLAS REHABILITATION INC	2504	\$5,699.00			321 New Orleans
EDMUND PEREIRA	2504	\$10,800.00			459 Honolulu
EDMUND PEREIRA	2505		\$18,750.00		459 Honolulu
ELLIS VOCATIONAL SVCS	2504	\$950.00			343 Oakland
ELLIS VOCATIONAL SVCS	2505		\$4,550.00		343 Oakland
EMPLOYMENT RESOURCE NETWORK	2505		\$4,680.00		348 Portland
EMPLOYMENT RESOURCES GROUP	2506			\$56,160.00	351 Muskogee
ENGLAND & CO REHAB SVCS INC	2505		\$3,848.00		328 Chicago
ENGLAND & CO REHAB SVCS INC	2506			\$36,433.74	328 Chicago
EVANSVILLE GOODWILL INDS INC	2505		\$22,335.00		326 Indianapolis
EVANSVILLE GOODWILL INDS INC	2506			\$700.00	326 Indianapolis
EVERGREEN HOSP HEAD INJURY	2504	\$1,690.00			346 Seattle
FAMILY PACIFIC	2505		\$2,500.00		459 Honolulu
FLOYD & ASSOCS LLC	2504	\$25,858.00			346 Seattle
FOSTER ASSESSMENT CTR	2504	\$32,805.00			344 Los Angeles
FOSTERS ASSES AND TESTING CTR	2504	\$27,335.00			344 Los Angeles
FRESH START REHAB	2504	\$24,950.00			317 St. Petersburg
FRESH START REHAB	2505		\$95,200.30		317 St. Petersburg
G E DEANER PHD CRC	2504	\$4,600.00			343 Oakland
GENERAUX BUSINESS CONSULTANTS	2504	\$1,525.00			354 Reno
GENEX	2504	\$13,655.00			328 Chicago
GENEX	2504	\$57,115.00			339 Denver
GENEX	2504	\$1,950.00			442 Cheyenne
GENEX	2505		\$29,230.00		328 Chicago
GENEX	2505		\$15,520.00		348 Portland
GENEX	2505		\$6,700.00		362 Houston
GENEX	2506			\$2,165.65	328 Chicago
GENEX SERVICES INC	2504	\$1,008.00			343 Oakland
GENEX SERVICES INC	2505		\$2,450.00		362 Houston
GEORGE MOORE & ASSOCS INC	2504	\$43,011.00			313 Baltimore
GEORGE MOORE & ASSOCS INC	2504	\$71,674.00			372 Washington
GEORGE MOORE & ASSOCS INC	2505		\$30,604.00		372 Washington
GEORGE MOORE & ASSOCS INC	2506			\$3,307.00	313 Baltimore
GEORGE MOORE & ASSOCS INC	2506			\$5,433.00	372 Washington
GLAPION COUNSELING & CONSULT	2504	\$6,480.00			343 Oakland

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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
GOODWILL INDS OF CENTRAL IN	2506			\$6,350.00	326 Indianapolis
GOODWILL INDS OF KYOWVA	2504	\$550.00			315 Huntington
GOODWILL INDS OF MIDDLE TN INC	2504	\$760.00			320 Nashville
GOODWILL INDS OF MIDDLE TN INC	2505		\$2,812.00		320 Nashville
GOODWILL INDS OF MIDDLE TN INC	2506			\$1,596.00	320 Nashville
GOODWILL INDS OF NE IN INC	2504	\$0.20			326 Indianapolis
GOODWILL INDS OF NE IN INC	2505		\$29,422.94		326 Indianapolis
GOODWILL INDS OF NE IN INC	2506			\$4,294.47	326 Indianapolis
GOODWILL INDS OF SPRINGFIELD	2504	\$1,250.74			301 Boston
GRAMS & ASSOCS	2504	\$200.00			343 Oakland
GRAMS & ASSOCS	2505		\$650.00		343 Oakland
HASKINS REHAB SVCS	2505		\$330.00		343 Oakland
HOUCK LIMITED	2504	\$14,541.00			315 Huntington
HOUCK LIMITED	2504	\$41,952.00			325 Cleveland
HOUCK LIMITED	2505		\$4,028.00		315 Huntington
HOUCK LIMITED	2505		\$27,252.00		325 Cleveland
HOUCK LIMITED	2506			\$1,500.00	315 Huntington
HOUCK LIMITED	2506			\$432.00	325 Cleveland
HU ANI & ASSOCS	2504	\$22,975.00			329 Detroit
HUFFY SERVICE FIRST	2506			\$542.50	325 Cleveland
HUGO ROMAN MD	2504	\$26,080.00			355 San Juan
HUMAN SVCS OUTCOMES INC	2504	\$7,690.00			317 St Petersburg
HUMAN SVCS OUTCOMES INC	2504	\$65,208.00			340 Albuquerque
I N K VOCATIONAL COUNSELING	2504	\$9,050.00			343 Oakland
INTERMOUNTAIN WEST REHAB	2504	\$3,744.00			339 Denver
INTL CTR FOR THE DISABLED	2504	\$88,025.00			306 New York
INTL CTR FOR THE DISABLED	2505		\$25,650.00		306 New York
INTL CTR FOR THE DISABLED	2506			\$350.00	306 New York
INTRACORP	2505		\$21,024.00		348 Portland
INTRACORP	2506			\$7,811.15	318 Winston-Salem
INTRACORP INC	2504	\$5,629.00			335 St Paul
INTRACORP INC	2505		\$4,331.09		335 St Paul
INTRACORP INC	2505		\$5,376.00		348 Portland
INTRACORP INC	2506			\$685.00	318 Winston-Salem
INTRACORP INC	2506			\$1,936.00	335 St Paul
IRA H COMBS EDD	2504	\$61,380.00			328 Chicago
IRA H COMBS EDD & ASSOCS	2505		\$1,665.00		327 Louisville
IRA H COMBS EDD & ASSOCS	2504	\$310.00			320 Nashville
IRA H COMBS EDD & ASSOCS	2504	\$32,210.00			328 Chicago
IRA H COMBS EDD & ASSOCS	2505		\$7,335.00		327 Louisville
IRA H COMBS EDD & ASSOCS	2505		\$150.00		328 Chicago
J MAGROWSKI PHD	2505		\$1,350.00		331 St Louis
J R FLETCHER CONSULTING	2506			\$2,125.00	460 Wilmington
J SCOTT LANKFORD	2504	\$21,600.00			322 Montgomery
JAMES B ADAMS	2504	\$2,470.00			320 Nashville
JAMES B ADAMS & ASSOC INC	2504	\$9,610.00			319 Columbia
JAMES B ADAMS & ASSOC INC	2504	\$3,720.00			328 Chicago

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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
JAMES B ADAMS ASSOC INC	2504	\$57,030.00			319 Columbia
JAMES B ADAMS ASSOC INC	2504	\$52,480.00			328 Chicago
JAMES B ADAMS ASSOC INC	2505		\$310.00		319 Columbia
JAMES B ADAMS ASSOC INC	2505		\$310.00		328 Chicago
JAY KIND PHD	2504	\$1,125.00			309 Newark
JEREMY R THAYER	2505		\$775.00		313 Baltimore
JEWISH VOCATIONAL SVC	2504	\$4,284.00			331 St. Louis
JOB READY INC	2506			\$2,000.00	463 Anchorage
JOBS PLUS INC	2506			\$19,500.00	330 Milwaukee
JOCELYN LANGREHR MS	2504	\$550.00			460 Wilmington
JOHNSON & SPAVENTA	2504	\$82,670.00			344 Los Angeles
JOSEPH G LAW JR	2504	\$35,500.00			322 Montgomery
JOSEPH G LAW JR	2506			\$150.00	322 Montgomery
K R BRADFORD	2506			\$1,200.00	320 Nashville
K TREXLER ELLINGTON PHD	2504	\$6,175.00			341 Salt Lake City
K WHITE	2504	\$4,800.00			442 Cheyenne
KELLI BOWSER	2505		\$26,720.76		311 Pittsburgh
KELLY WHITE	2504	\$1,200.00			442 Cheyenne
KELLY WHITE	2505		\$600.00		442 Cheyenne
KITT MURRISON PHD	2504	\$600.00			343 Oakland
KRABACH INC	2504	\$500.00			339 Denver
L A HUEBNER PHD	2504	\$1,000.00			341 Salt Lake City
L BONURA	2506			\$1,000.00	362 Houston
LAURIE BARASH	2504	\$60.00			345 Phoenix
LAURIE BARASH	2506			\$861.00	345 Phoenix
LEARNING CENTER	2504	\$435.00			311 Pittsburgh
LINDA PARKER & ASSOC	2504	\$23,780.00			344 Los Angeles
LINDA S WALDROP OTR	2504	\$2,160.61			320 Nashville
LINDA S WALDROP OTR	2505		\$582.13		320 Nashville
LINK EMPLOY ABILITY POTENTIAL	2506			\$1,166.67	325 Cleveland
LISA B THOMAS	2504	\$900.00			322 Montgomery
LISA B THOMAS	2504	\$34,199.95			323 Jackson
LISA B THOMAS	2505		\$4,987.00		322 Montgomery
LISA B THOMAS	2506			\$3,375.00	322 Montgomery
LOS AMIGOS RESEARCH &	2504	\$605.00			343 Oakland
M C HARDSOCC	2504	\$5,500.00			442 Cheyenne
M C HARDSOCC	2506			\$550.00	442 Cheyenne
M L STINSON & ASSOCS	2505		\$3,900.00		343 Oakland
M V R CONSULTING SERVICES INC	2504	\$53,625.00			438 Sioux Falls
MALCOLM D FARMER	2504	\$7,250.00			315 Huntington
MALCOLM D FARMER	2505		\$1,750.00		315 Huntington
MANAGED CARE NETWORK	2504	\$1,300.00			307 Buffalo
MANAGED CARE NETWORK	2505		\$71,970.00		307 Buffalo
MANAGED CARE NETWORK	2506			\$78,125.00	307 Buffalo
MANZANITA INC	2504	\$6,350.00			341 Salt Lake City
MARGARET SANCHEZ	2504	\$2,200.00			343 Oakland
MARK S SMASAL PHD	2504	\$800.00			341 Salt Lake City

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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
MARY JO WHITE	2504	\$650.00			317 St Petersburg
MARY JO WHITE	2505		\$75.00		317 St Petersburg
MEMPHIS GOODWILL IND	2505		\$5,200.00		320 Nashville
MERS MISSOURI GOODWILL INDS	2504	\$455.00			331 St. Louis
MERSMAN & SMITH VOCATIONAL	2504	\$4,000.00			343 Oakland
MICHAEL A FRANK & ASSOCS	2504	\$4,410.00			343 Oakland
MICHAEL A FRANK & ASSOCS	2505		\$2,400.00		343 Oakland
N HUGHES	2506			\$7,450.00	320 Nashville
N R V VENTURES INC PS	2504	\$26,075.00			346 Seattle
NANCY HENDERSON & ASSOCS INC	2504	\$124,095.00			344 Los Angeles
NANCY HENDERSON & ASSOCS INC	2505		\$355.00		344 Los Angeles
NANCY HENDERSON & ASSOCS INC	2506			\$660.00	344 Los Angeles
NATHALIE GENDRON LLC	2504	\$22,272.50			372 Washington
NATHALIE GENDRON LLC	2505		\$435,019.00		372 Washington
NATHALIE GENDRON LLC	2506			\$5,850.00	372 Washington
NELSON & ASSOCS REHAB SERVICES	2504	\$798.00			354 Reno
NEW CURATIVE REHAB INC	2506			\$3,000.00	330 Milwaukee
NEWAY DIRECTIONS	2506			\$1,800.00	330 Milwaukee
NORTHCOAST RESOURCE PARTNERS	2504	\$4,760.00			325 Cleveland
NORTHCOAST RESOURCE PARTNERS	2505		\$175.00		325 Cleveland
NORTHERN COLORADO VOCATIONAL	2504	\$5,500.00			442 Cheyenne
O S C VOCATIONAL SYSTEMS INC	2504	\$16,568.84			346 Seattle
OPPORTUNITIES & SOLUTIONS INC	2504	\$12,580.00			316 Atlanta
OPPORTUNITIES & SOLUTIONS INC	2504	\$105.00			317 St. Petersburg
OPPORTUNITIES & SOLUTIONS INC	2505		\$127,551.80		317 St. Petersburg
OPPORTUNITIES & SOLUTIONS INC	2506			\$890.00	317 St. Petersburg
P D M CONSULTING INC	2504	\$325.00			325 Cleveland
P D M CONSULTING INC	2505		\$57,028.50		325 Cleveland
P LG TAIMANGLO PHD	2504	\$10,050.00			459 Honolulu
PADILLA INVESTIGATIONS & CONS	2504	\$2,450.00			347 Boise
PARTNERS IN PLACEMENT INC	2506			\$3,772.00	320 Nashville
PECKHAM INC	2504	\$425.00			329 Detroit
PIONEER REHAB INC	2504	\$198,487.50			316 Atlanta
PIONEER REHAB INC	2505		\$365.00		316 Atlanta
PLACEMENT OPPORTUNITIES	2506			\$2,700.00	330 Milwaukee
PROCURA MGMT INC	2504	\$600.00			460 Wilmington
PROF REHABILITATION MGMT INC	2505		\$6,560.00		328 Chicago
PROFESSIONAL CONSULTING SVCS	2505		\$11,054.70		348 Portland
PROGRESSIVE REHAB SVCS INC	2504	\$9,000.00			339 Denver
PROGRESSIVE REHAB SVCS INC	2505		\$14,968.75		339 Denver
PROGRESSIVE VOCATIONAL SVCS	2504	\$7,600.00			315 Huntington
PROGRESSIVE VOCATIONAL SVCS	2506			\$3,000.00	315 Huntington
R B FRANCE PHD	2504	\$6,210.43			341 Salt Lake City
R G TAYLOR	2504	\$525.00			341 Salt Lake City
R P DICKOW	2504	\$13,950.00			329 Detroit
R T W SERVICES INC	2504	\$2,115.00			329 Detroit
R W DETLING	2505		\$32,063.46		311 Pittsburgh

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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
R WRIGHT OPTIC	2505		\$390.00		313 Baltimore
REGL REHAB	2505		\$21,450.00		348 Portland
REHAB ADVISORS INC	2505		\$175,300.00		317 St. Petersburg
REHAB ADVISORS INC	2506			\$100.00	317 St. Petersburg
REHAB PERSPECTIVES INC	2504	\$4,026.66			313 Baltimore
REHAB PERSPECTIVES INC	2504	\$1,890.00			314 Roanoke
REHAB PERSPECTIVES INC	2504	\$3,825.00			372 Washington
REHAB PERSPECTIVES INC	2505		\$425.00		372 Washington
REHAB SERVICES UNLIMITED	2504	\$28,420.00			313 Baltimore
REHAB SERVICES UNLIMITED	2506			\$200.00	313 Baltimore
REHAB SPECIALISTS GROUP INC	2504	\$7,843.50			345 Phoenix
REHAB SPECIALISTS GROUP INC	2505		\$5,132.50		345 Phoenix
REHAB SPECIALISTS GROUP INC	2506			\$1,020.00	345 Phoenix
REHAB TEAM ASSOCS INC	2504	\$67,275.00			329 Detroit
REHAB TEAM ASSOCS INC	2505		\$325.00		329 Detroit
REHAB TEAM ASSOCS INC	2506			\$2,600.00	329 Detroit
RESOURCE CONSULTANTS INC	2504	\$834.00			317 St. Petersburg
RESOURCE CONSULTANTS INC	2505		\$280.00		317 St. Petersburg
RESULTS & ASSOCS	2506			\$29,750.00	313 Baltimore
RICARDO AGUAYO	2504	\$300.00			327 Louisville
RINLY R GECOSALA MD PC	2504	\$325.00			345 Phoenix
RIPP REHAB INC	2504	\$900.00			345 Phoenix
RONALD L ROSENBERG PHD	2504	\$26,160.00			309 Newark
RSVP INC	2504	\$13,742.00			314 Roanoke
RTW VOCNL REHAB SERV	2504	\$25,895.00			325 Cleveland
RTW VOCNL REHAB SERV	2504	\$1,050.00			329 Detroit
RTW VOCNL REHAB SERV	2505		\$83,592.00		325 Cleveland
RTW VOCNL REHAB SERV	2506			\$26.00	325 Cleveland
S B SCHMIDT	2504	\$2,000.00			343 Oakland
S B SCHMIDT	2505		\$9,500.00		343 Oakland
S G KREUTER	2504	\$1,008.00			321 New Orleans
S J JENSEN	2504	\$12,400.00			339 Denver
S J JENSEN	2505		\$71,894.00		339 Denver
S J JENSEN	2506			\$332.00	339 Denver
SANDRA A POLIAKOFF	2504	\$14,800.00			316 Atlanta
SARAH J JENSEN	2504	\$8,870.00			339 Denver
SARAH J JENSEN	2505		\$38,429.00		339 Denver
SARAH J JENSEN	2506			\$415.00	339 Denver
SCHMIDT VOCATIONAL SERVICES LL	2504	\$21,500.00			437 Fargo
SEQUIT	2505		\$990.00		345 Phoenix
SEYLER FAVALORO LTD	2504	\$20,430.00			321 New Orleans
SISKIN HOSP FOR PHYSICAL REHAB	2504	\$500.00			320 Nashville
SOMERS VOCATIONAL GUIDANCE	2504	\$53,530.00			344 Los Angeles
SOUTHERN ILLINOIS UNIV	2504	\$1,995.00			328 Chicago
STONEBRIDGE REHAB	2505		\$78,422.50		348 Portland
STUBBE & ASSOCS	2504	\$46,293.00			334 Lincoln
STUBBE & ASSOCS	2505		\$1,818.00		334 Lincoln

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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
STUBBE & ASSOCS INC 5082	2504	\$34,408.06			335 St. Paul
STUBBE & ASSOCS INC 5082	2506			\$4,300.00	335 St. Paul
T YOUNG	2504	\$20,750.00			325 Cleveland
T YOUNG	2504	\$625.00			326 Indianapolis
T YOUNG	2505		\$13,233.00		326 Indianapolis
TERRILL & ASSOCS INC	2504	\$12,705.00			452 Wichita
TIM W FICKLIN	2504	\$40,580.00			351 Muskogee
TIM W FICKLIN	2505		\$300.00		351 Muskogee
TIRR GROUP INC	2504	\$173,483.00			377 San Diego
TIRR GROUP INC	2505		\$2,260.00		377 San Diego
TOTAL VOCATIONAL SERVICES	2504	\$7,621.00			346 Seattle
TOURO INFIRMARY	2504	\$6,359.00			321 New Orleans
TOURO INFIRMARY	2506			\$220.00	321 New Orleans
TRAC ASSOCS INC	2504	\$18,260.00			346 Seattle
TRAC ASSOCS INC	2505		\$156,530.00		346 Seattle
TRI AREA REHAB SVCS INC	2504	\$26,250.00			313 Baltimore
TRI AREA REHAB SVCS INC	2504	\$750.00			314 Roanoke
TRI AREA REHAB SVCS INC	2504	\$4,500.00			372 Washington
TRI AREA REHAB SVCS INC	2506			\$800.00	313 Baltimore
UNIV OF WISCONSIN	2506			\$8,700.00	330 Milwaukee
VANGUARD CAREER SVS	2506			\$5,690.00	306 New York
VANGUARD CAREER SVS	2506			\$19,060.00	309 Newark
VERMEER REHAB SERVICES	2504	\$86,470.00			339 Denver
VERMEER REHAB SERVICES	2504	\$3,510.00			442 Cheyenne
VERMEER REHAB SERVICES	2505		\$585.00		339 Denver
VESSELL VOC SVCS	2504	\$1,500.00			320 Nashville
VESSELL VOC SVCS	2504	\$500.00			322 Montgomery
VESSELL VOC SVCS	2505		\$500.00		320 Nashville
VESSELL VOC SVCS	2505		\$6,300.00		322 Montgomery
VESSELL VOC SVCS	2506			\$59,700.00	320 Nashville
VESSELL VOC SVCS	2506			\$975.00	322 Montgomery
VICKIE PRATTON MS	2504	\$20,900.00			322 Montgomery
VICKIE PRATTON MS	2505		\$550.00		322 Montgomery
VICTORIA A SAUNDERS	2505		\$34,975.00		362 Houston
VISION INTEGRATED PROGRAMS	2504	\$17,824.99			321 New Orleans
VISION INTEGRATED PROGRAMS	2505		\$62.50		321 New Orleans
VISION INTEGRATED PROGRAMS	2506			\$470.00	321 New Orleans
VOCATIONAL DESIGNS INC	2504	\$3,520.00			343 Oakland
VOCATIONAL DESIGNS INC	2504	\$3,195.00			344 Los Angeles
VOCATIONAL DESIGNS INC	2505		\$10,665.00		343 Oakland
VOCATIONAL MANAGEMENT	2504	\$52,800.00			463 Anchorage
VOCATIONAL SERVICES INC	2504	\$44,145.00			463 Anchorage
VOCWORKS	2504	\$690.00			326 Indianapolis
VOCWORKS	2505		\$5,950.00		326 Indianapolis
VOCWORKS LTD	2505		\$5,808.00		326 Indianapolis
WELLNESS INSTITUTE INC	2504	\$23,795.00			321 New Orleans
WKU RESEARCH FDN INC	2505		\$17,940.00		327 Louisville

Vocational Rehabilitation and Employment Service
 Listing of Contractor Expenditures for FY 2004
 February 1, 2005

Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
XPRT PLACEMENT LLC	2506			\$4,500.00	330 Milwaukee
YANO REHAB INC	2504	\$1,300.00			313 Baltimore
YANO REHAB INC	2504	\$5,125.50			315 Huntington
YANO REHAB INC	2504	\$12,238.05			372 Washington
YANO REHAB INC	2505		\$8,869.00		313 Baltimore
YANO REHAB INC	2505		\$1,780.00		372 Washington
YANO REHAB INC	2506			\$919.80	313 Baltimore
TOTALS		\$4,090,574.49	\$2,533,814.28	\$441,861.96	

ORIGINAL CLAIMS COMPLETED
FY 2001-2004

	EP 110 - DISABILITY COMPENSATION, 1 EP 610 - DISABILITY COMPENSATION, 8 TO 7 ISSUES				EP 100 - DISABILITY PENSION				EP 140 - DEATH COMPENSATION/DC				EP 190 - DEATH PENSION			
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004	FY 2001	FY 2002	FY 2003	FY 2004
Eastern Area	67,679	81,467	142,100	133,162	18,721	22,453	32,461	38,422	20,560	19,933	26,129	31,241	13,848	15,273	22,141	24,431
Alabama	970	1,243	2,456	2,135	386	503	761	723	277	354	536	418	235	257	418	311
Arizona	1,292	2,319	3,028	2,867	47	181	338	384	411	651	659	539	186	238	311	506
California	1,561	2,977	4,058	3,814	164	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Colorado	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Connecticut	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Florida	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Georgia	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Hawaii	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Idaho	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Illinois	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Indiana	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Iowa	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Kansas	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Kentucky	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Louisiana	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Maine	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Maryland	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Massachusetts	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Michigan	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Minnesota	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Mississippi	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Missouri	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Montana	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Nebraska	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Nevada	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
New Hampshire	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
New Jersey	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
New Mexico	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
New York	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
North Carolina	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
North Dakota	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Ohio	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Oklahoma	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Oregon	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Pennsylvania	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Rhode Island	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
South Carolina	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
South Dakota	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Tennessee	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Texas	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Utah	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Vermont	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Virginia	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Washington	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
West Virginia	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Wisconsin	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Wyoming	1,657	3,977	5,458	5,148	184	226	333	364	1,030	1,278	1,552	1,452	538	405	1,274	818
Southern Area	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Alabama	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Arizona	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
California	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Colorado	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Connecticut	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Delaware	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
District of Columbia	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Florida	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Georgia	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Hawaii	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Idaho	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Illinois	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Indiana	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Iowa	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Kansas	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Kentucky	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Louisiana	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Maine	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Maryland	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Massachusetts	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Michigan	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Minnesota	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Mississippi	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Missouri	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Montana	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Nebraska	1,043	2,115	4,123	4,238	427	512	961	1,021	71	65	124	124	47	81	114	121
Nevada	1,043	2,115	4,123	4,238	427	512	961	1,021								

Anchorage	Date of Form 9	Date of Remand
463	7/31/2000	7/26/2004
463	2/23/2001	10/15/2004
463	1/10/2003	11/1/2004
463	2/13/2002	9/10/2003
463	7/11/2001	1/6/2005
463	12/30/2002	11/8/2004
463	4/5/2002	10/16/2003
463	4/15/2002	3/10/2004
463	8/15/2000	7/28/2003
463	5/21/1997	10/27/2003
463	5/28/2002	3/10/2004
463	1/28/2003	12/3/2004
463	7/1/2003	1/14/2005
463	2/20/2002	9/5/2003
463	1/18/2001	2/20/2004
463	4/11/2000	5/28/2004
463	3/15/1999	9/3/2003
463	7/17/2003	1/12/2005
463	10/2/2002	10/6/2004
463	5/12/1997	8/21/2003
463	12/5/2003	9/24/2004
463	1/25/2001	9/12/2003
463	4/22/2002	12/31/2003
463	6/12/2003	9/16/2004
463	8/5/2002	12/30/2003
463	1/21/2003	12/30/2004
463	1/25/2002	8/25/2004
463	3/19/2003	12/30/2004
463	3/10/2003	10/20/2004
463	5/31/1995	10/7/2004
463	5/16/2000	6/21/2004

463	7/30/2002	9/20/2004
463	7/6/1995	11/7/2003
463	9/27/2000	8/29/2003
463	3/15/2002	11/13/2003
463	4/17/2000	10/14/2003
463	3/22/2000	9/10/2003
463	2/7/2001	12/1/2004
463	7/21/2003	1/6/2005
463	1/31/2003	10/26/2004
463	3/25/1999	10/10/2003
463	2/14/2002	10/15/2004
463	5/15/2000	9/29/2003
463	7/16/2003	12/13/2004
463	1/17/2001	4/15/2004
463	4/10/2003	12/15/2004

	Average Days to Complete a Rating Decision				Average Days a Rating Decision is Pending			
	EOM Sep-02	FYTD FY03	EOM Sep-04	EOM Sep-05	FY02	FY03	FY04	FY05
Nationwide	185.3	165.0	100.0	130.0	178.0	100.0	90.0	100.0
Eastern Area								
Baltimore	144.6	177.7	105.9	131.8	145.0	101.0	109.7	104.3
Boston	196.8	134.8	113.8	129.8	159.4	93.4	110.3	101.5
Buffalo	192.2	179.4	111.8	135.9	202.5	113.4	120.9	106.4
Cleveland	222.3	178.4	101.7	134.5	177.0	103.4	97.8	100.6
Detroit	180.7	162.8	111.9	136.7	186.0	102.0	115.9	97.9
Hartford	191.3	147.4	94.0	133.6	165.4	91.1	76.3	91.6
Indianapolis	176.2	151.3	99.0	130.0	165.0	99.5	78.0	95.1
Manchester	168.8	157.1	102.8	132.4	113.3	96.3	92.9	96.1
New York	189.8	189.4	110.0	138.5	190.0	114.1	116.1	112.7
Newark	189.8	224.8	119.2	134.0	190.0	114.4	118.6	103.4
Philadelphia	189.8	172.4	101.3	127.5	186.0	108.8	100.9	100.8
Pittsburgh	174.0	107.6	91.5	132.2	159.7	86.1	88.3	110.7
Providence	240.8	210.8	119.6	133.2	239.6	117.2	108.4	90.8
Togus	128.2	144.7	96.9	126.4	130.3	96.9	83.0	88.4
White River Jct	160.2	168.7	99.4	115.0	155.4	101.0	99.0	89.3
Wilmington	194.3	226.1	115.2	139.1	195.0	114.9	124.8	103.1
Southern Area								
Atlanta	183.0	191.8	104.0	126.1	192.0	112.3	92.3	96.6
Columbia	144.8	139.8	93.5	120.8	136.0	88.2	77.2	91.0
Huntington	144.8	175.5	97.1	126.9	269.0	100.5	79.0	97.3
Jackson	136.7	120.4	88.9	127.3	130.0	89.4	74.4	91.4
Louisville	167.2	200.3	121.3	139.8	202.0	118.7	117.9	114.3
Montgomery	162.2	146.7	103.2	135.1	162.0	97.1	77.2	108.2
Nashville	180.7	152.1	94.6	123.4	144.0	91.1	78.6	84.3
Roanoke	216.9	203.8	107.8	138.3	190.0	106.1	98.6	109.2
San Juan	191.9	185.4	95.3	120.5	162.0	93.8	78.1	94.4
St. Petersburg	182.8	140.9	93.0	122.3	155.0	92.9	78.1	96.5
Washington	329.2	267.2	93.5	134.5	417.8	132.8	104.5	120.7
Winston-Salem	193.9	153.6	90.8	125.6	190.0	99.1	78.2	93.0
Central Area								
Chicago	161.8	133.0	95.1	137.7	168.0	85.8	86.5	108.2
Des Moines	156.3	166.3	107.9	138.9	158.0	101.4	95.8	106.7
Fargo	147.3	143.1	96.3	120.1	142.0	93.2	77.8	90.5
Houston	148.2	113.8	91.6	129.9	140.5	80.4	73.8	103.5
Lincoln	147.3	122.1	86.5	122.6	142.0	80.9	74.4	90.5
Little Rock	171.7	145.4	103.6	135.4	131.2	94.5	91.0	92.2
Milwaukee	161.8	195.3	102.3	128.5	158.0	107.6	98.8	92.1
Muskogee	162.7	123.7	91.9	122.5	158.5	87.0	79.1	89.6
New Orleans	157.3	123.6	95.0	127.3	153.0	90.3	78.4	93.3
Sioux Falls	140.1	138.5	98.2	122.6	158.0	92.6	91.4	91.9
St. Louis	171.7	146.2	101.6	124.2	165.0	96.0	91.6	91.3
St. Paul	156.3	142.5	101.5	125.7	142.0	93.6	89.1	96.5
Waco	169.0	156.7	98.3	128.0	169.4	94.2	85.6	99.0
Wichita	208.8	220.2	114.4	142.6	184.0	115.7	104.8	118.8
Western Area								
Albuquerque	189.8	154.1	97.0	127.5	190.0	98.9	83.8	95.2
Anchorage	203.3	208.2	114.2	132.4	200.0	106.6	108.2	106.0
Boise	189.8	115.2	95.4	128.5	190.0	84.1	77.6	90.1
Denver	213.1	172.7	97.8	119.7	190.0	100.8	75.5	110.5
Ft. Harrison	180.7	128.9	97.1	130.9	190.0	93.5	83.3	99.4
Honolulu	235.0	220.2	116.0	148.0	209.1	114.1	115.8	104.3
Los Angeles	216.9	173.4	107.8	144.8	187.2	107.2	89.6	101.4
Manila	216.9	194.4	92.4	115.0	303.7	109.9	71.8	75.0
Oakland	239.5	218.4	106.3	132.0	230.0	111.8	93.6	100.2
Phoenix	198.8	161.9	98.0	131.2	180.0	92.9	89.2	100.2
Portland	203.3	205.6	116.9	139.4	200.0	121.7	110.0	105.1
Reno	237.7	225.7	109.2	139.9	190.0	115.9	104.7	99.0
Salt Lake City	144.6	91.0	86.8	115.0	145.0	77.8	71.3	87.5
San Diego	207.9	209.2	101.2	125.8	230.0	106.8	87.9	101.4
Seattle	194.3	158.7	100.1	137.8	190.0	95.5	85.9	105.2

	Rating Accuracy			Authorization Accuracy			Fiduciary Accuracy		
	FY03	FY04	FY05	FY03	FY04	FY05	FY03	FY04	FY05
Nationwide	88%	90%	90%	82%	87%	95%	85%	88%	85%
Eastern Area									
Baltimore	88%	90%	90%	82%	87%	95%	85%	88%	85%
Boston	88%	90%	90%	82%	87%	95%	85%	88%	85%
Buffalo	88%	90%	90%	82%	87%	95%	85%	88%	85%
Cleveland	88%	90%	90%	82%	87%	95%	85%	88%	85%
Detroit	88%	90%	90%	82%	87%	95%	85%	88%	85%
Hartford	88%	90%	90%	82%	87%	95%	85%	88%	85%
Indianapolis	88%	90%	90%	82%	87%	95%	85%	88%	85%
Manchester	88%	90%	90%	82%	87%	95%	85%	88%	85%
New York	88%	90%	90%	82%	87%	95%	85%	88%	85%
Newark	88%	90%	90%	82%	87%	95%	85%	88%	85%
Philadelphia	88%	90%	90%	82%	87%	95%	85%	88%	85%
Pittsburgh	88%	90%	90%	82%	87%	95%	85%	88%	85%
Providence	88%	90%	90%	82%	87%	95%	85%	88%	85%
Togus	88%	90%	90%	82%	87%	95%	85%	88%	85%
White River Jct.	88%	90%	90%	82%	87%	95%	85%	88%	85%
Wilmington	88%	90%	90%	82%	87%	95%	85%	88%	85%
Southern Area									
Atlanta	88%	90%	90%	82%	87%	95%	85%	88%	85%
Columbia	88%	90%	90%	82%	87%	95%	85%	88%	85%
Huntington	88%	90%	90%	82%	87%	95%	85%	88%	85%
Jackson	88%	90%	90%	82%	87%	95%	85%	88%	85%
Louisville	88%	90%	90%	82%	87%	95%	85%	88%	85%
Montgomery	88%	90%	90%	82%	87%	95%	85%	88%	85%
Nashville	88%	90%	90%	82%	87%	95%	85%	88%	85%
Roanoke	88%	90%	90%	82%	87%	95%	85%	88%	85%
San Juan	88%	90%	90%	82%	87%	95%	85%	88%	85%
St. Petersburg	88%	90%	90%	82%	87%	95%	85%	88%	85%
Washington	88%	90%	90%	82%	87%	95%	85%	88%	85%
Winston-Salem	88%	90%	90%	82%	87%	95%	85%	88%	85%
Central Area									
Chicago	88%	90%	90%	82%	87%	95%	85%	88%	85%
Des Moines	88%	90%	90%	82%	87%	95%	85%	88%	85%
Fargo	88%	90%	90%	82%	87%	95%	85%	88%	85%
Houston	88%	90%	90%	82%	87%	95%	85%	88%	85%
Lincoln	88%	90%	90%	82%	87%	95%	85%	88%	85%
Little Rock	88%	90%	90%	82%	87%	95%	85%	88%	85%
Milwaukee	88%	90%	90%	82%	87%	95%	85%	88%	85%
Muskogee	88%	90%	90%	82%	87%	95%	85%	88%	85%
New Orleans	88%	90%	90%	82%	87%	95%	85%	88%	85%
Sioux Falls	88%	90%	90%	82%	87%	95%	85%	88%	85%
St. Louis	88%	90%	90%	82%	87%	95%	85%	88%	85%
St. Paul	88%	90%	90%	82%	87%	95%	85%	88%	85%
Waco	88%	90%	90%	82%	87%	95%	85%	88%	85%
Wichita	88%	90%	90%	82%	87%	95%	85%	88%	85%
Western Area									
Albuquerque	88%	90%	90%	82%	87%	95%	85%	88%	85%
Anchorage	88%	90%	90%	82%	87%	95%	85%	88%	85%
Boise	88%	90%	90%	82%	87%	95%	85%	88%	85%
Denver	88%	90%	90%	82%	87%	95%	85%	88%	85%
Ft. Harrison	88%	90%	90%	82%	87%	95%	85%	88%	85%
Honolulu	88%	90%	90%	82%	87%	95%	85%	88%	85%
Los Angeles	88%	90%	90%	82%	87%	95%	85%	88%	85%
Manila	88%	90%	90%	82%	87%	95%	85%	88%	85%
Oakland	88%	90%	90%	82%	87%	95%	85%	88%	85%
Phoenix	88%	90%	90%	82%	87%	95%	85%	88%	85%
Portland	88%	90%	90%	82%	87%	95%	85%	88%	85%
Reno	88%	90%	90%	82%	87%	95%	85%	88%	85%
Salt Lake City	88%	90%	90%	82%	87%	95%	85%	88%	85%
San Diego	88%	90%	90%	82%	87%	95%	85%	88%	85%
Seattle	88%	90%	90%	82%	87%	95%	85%	88%	85%

Vocational Rehabilitation and Employment Service
Listing of Contractor Expenditures for FY 2004
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
A G ELLINGSON PHD	2504	\$4,515.00			341 Salt Lake City
A P JACKSON	2504	\$4,500.00			341 Salt Lake City
AASTUM VOCATIONAL SVCS INC	2504	\$10,575.00			347 Boise
AASTUM VOCATIONAL SVCS INC	2505		\$500.00		347 Boise
ABILITIES INC	2504	\$5,200.00			306 New York
ABILITIES INC	2505		\$14,250.00		306 New York
ABILITIES INC	2506			\$250.00	306 New York
ACCESS CASE MGMT SERVICES	2504	\$65,381.00			316 Atlanta
ACCESS CASE MGMT SERVICES	2506			\$286.00	316 Atlanta
ACTION REHAB	2504	\$2,460.00			345 Phoenix
ACTION REHAB	2505		\$19,810.00		345 Phoenix
ALARIS GRP INC	2504	\$49,950.00			437 Fargo
ALASKA VOCATIONAL & COUNSELING	2504	\$1,200.00			463 Anchorage
ALLIED COMMUNITY RESOURCES INC	2504	\$6,375.00			301 Boston
ALTERNATIVE CAREERS	2505		\$3,500.00		343 Oakland
AMANDA M THIENEMAN	2504	\$100.00			327 Louisville
ANFUSO VACTIONAL SVCS INC	2504	\$81,090.00			344 Los Angeles
ASSOCIATED THERAPEUTICS INC	2505		\$1,563.51		320 Nashville
B M PRESTONBACK	2504	\$12,000.00			321 New Orleans
BARBEE & ASSOCS	2505		\$18,450.00		362 Houston
BEST VOCATIONAL CONS INC	2504	\$28,540.00			339 Denver
BEST VOCATIONAL CONS INC	2505		\$60,934.00		339 Denver
BEST VOCATIONAL CONS INC	2506			\$166.00	339 Denver
BLACK HILLS SPECIAL SERVICES	2504	\$58,405.00			438 Sioux Falls
BRUCE W COLEMAN	2505		\$1,950.00		343 Oakland
C DAMICO	2504	\$1,050.00			318 Winston-Salem
C E M	2504	\$3,905.00			344 Los Angeles
C E PHIPPS	2504	\$60,809.30			314 Roanoke
C R C SERVICES	2504	\$43,850.00			301 Boston
C R MCARTHUR PHD	2504	\$56,100.00			322 Montgomery
C S VOCATIONAL CONSULTANTS LTD	2504	\$36,400.00			334 Lincoln
C VET INC	2504	\$22,207.00			321 New Orleans
CAIRNS COUNSELING CENTER	2504	\$885.00			377 San Diego
CAPABILITIES FOR LIVING LLC	2504	\$1,000.00			320 Nashville
CAPABILITIES FOR LIVING LLC	2505		\$1,586.14		320 Nashville
CAPIELANO & ASSOCS INC	2504	\$1,500.00			321 New Orleans
CAPITOL CITY REHAB GROUP	2504	\$4,964.00			349 Waco
CAPITOL CITY REHAB GROUP	2504	\$49,905.00			351 Muskogee
CAPITOL CITY REHAB GROUP	2505		\$329.00		351 Muskogee
CAPITOL CITY REHAB GROUP	2506			\$2,370.00	349 Waco
CAPITOL CITY REHAB GROUP	2506			\$3,450.00	351 Muskogee
CAREER ACTION ASSOCS PC	2506			\$8,840.00	349 Waco
CAREER DIRECTIONS OF RICHMOND	2504	\$1,500.00			314 Roanoke
CAREER MANAGEMENT SERVICES	2504	\$118,975.00			377 San Diego
CAREER OPTIONS INC	2504	\$52,734.16			314 Roanoke
CAREER OPTIONS INC	2505		\$225,893.57		314 Roanoke
CAREER SERVICES INC	2504	\$103,461.00			377 San Diego

Vocational Rehabilitation and Employment Service
 Listing of Contractor Expenditures for FY 2004
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
CAREER SERVICES INC	2506			\$265.00	377 San Diego
CASTELLANA & ASSOCIATES INC	2504	\$2,100.00			329 Detroit
CASTLE VOCATIONAL SVCS	2506			\$322.24	347 Boise
CEM	2504	\$27,585.00			344 Los Angeles
CERTIFIED CAREER CONSULTANTS	2504	\$24,611.50			377 San Diego
CERTIFIED VOC EVALUATION SVCS	2504	\$495.00			345 Phoenix
CHARLES G CARLISE	2504	\$680.00			345 Phoenix
CHRIS GEORGEFF & ASSOCS	2505		\$11,025.00		326 Indianapolis
CHRIS GEORGEFF & ASSOCS	2506			\$1,650.00	326 Indianapolis
CHRYSLIS COUNSELING CTR INC	2504	\$5,100.00			339 Denver
CIDDIO MORRIS ASSOCS INC	2504	\$11,254.00			343 Oakland
CIDDIO MORRIS ASSOCS INC	2505		\$3,750.00		343 Oakland
COMM PARTNERSHIP OF IDAHO INC	2504	\$18,050.00			347 Boise
CONCENTRA INTEGRATED SERVICE	2504	\$800.00			323 Jackson
CONCENTRA INTEGRATED SERVICE	2504	\$12,480.00			329 Detroit
CONCENTRA INTEGRATED SERVICE	2506			\$7,516.20	318 Winston-Salem
CONCENTRA INTEGRATED SVCS INC	2504	\$42,000.00			301 Boston
CONCENTRA INTEGRATED SVCS INC	2505		\$68,545.00		317 St. Petersburg
CONCENTRA INTEGRATED SVCS INC	2506			\$420.00	317 St. Petersburg
CONCENTRA MNGD CARE SVCS INC	2504	\$21,750.00			304 Providence
CONCENTRA MNGD CARE SVCS INC	2504	\$45.00			322 Montgomery
CONCENTRA MNGD CARE SVCS INC	2504	\$14,144.00			323 Jackson
CONCENTRA MNGD CARE SVCS INC	2504	\$16,224.00			329 Detroit
CONCENTRA MNGD CARE SVCS INC	2505		\$835.00		322 Montgomery
CONCENTRA MNGD CARE SVCS INC	2506			\$416.01	318 Winston-Salem
CONNECTIONS	2504	\$3,300.00			343 Oakland
CONNECTIONS	2505		\$14,075.00		343 Oakland
CONSULTATIVE REVIEW & REHAB	2506			\$210.00	309 Newark
COREY WOODRING	2505		\$10,300.00		309 Newark
CORVEL CORP	2504	\$108,245.00			316 Atlanta
CORVEL CORP	2504	\$18,480.00			322 Montgomery
CORVEL CORP	2505		\$520.00		316 Atlanta
CORVEL CORP	2505		\$880.00		322 Montgomery
CORVEL CORP	2505		\$10,589.00		348 Portland
CORVEL CORP	2505		\$27,125.00		362 Houston
CORVEL CORP	2506			\$195.00	316 Atlanta
CORVEL CORP	2506			\$6,856.53	322 Montgomery
CORVEL HEALTHCARE CORP	2504	\$480.00			316 Atlanta
COUNSELING RESOURCE CTR	2504	\$240.00			327 Louisville
COUNSELING RESOURCE CTR	2505		\$2,904.00		326 Indianapolis
COUNSELING RESOURCE CTR	2505		\$22,420.00		327 Louisville
COURTRIGHT & ASSOCS	2504	\$5,400.00			317 St. Petersburg
COURTRIGHT & ASSOCS	2505		\$2,921.05		317 St. Petersburg
CRAWFORD & CO	2504	\$472.00			321 New Orleans
CRAWFORD & CO	2504	\$19,912.00			346 Seattle
CRAWFORD & CO	2504	\$7,990.00			459 Honolulu
CRAWFORD & CO	2505		\$26,300.00		459 Honolulu

Vocational Rehabilitation and Employment Service
Listing of Contractor Expenditures for FY 2004
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
D A KING	2504	\$224.00			325 Cleveland
D A KING	2505		\$96.00		325 Cleveland
D J UHLENKOTT & ASSOCS	2504	\$7,850.00			346 Seattle
D W UPCHURCH	2504	\$48,300.00			319 Columbia
DAVID A ZAK	2505		\$35,863.08		311 Pittsburgh
DEMAREST ASSOCS LTD	2504	\$1,360.00			460 Wilmington
DESERT VOCATIONAL SERVICES	2504	\$118,000.00			377 San Diego
DETTMER VOCATIONAL CONS	2504	\$5,500.00			343 Oakland
DETTMER VOCATIONAL CONS	2505		\$13,250.00		343 Oakland
DEVINNEY & DINNEEN CAREER	2504	\$56,853.00			354 Reno
DIANA C SIMS & ASSOCS INC	2505		\$6,930.00		313 Baltimore
DISABILITY ACTION CENTER	2504	\$350.00			319 Columbia
DOUGLAS REHABILITATION INC	2504	\$5,699.00			321 New Orleans
EDMUND PEREIRA	2504	\$10,800.00			459 Honolulu
EDMUND PEREIRA	2505		\$18,750.00		459 Honolulu
ELLIS VOCATIONAL SVCS	2504	\$950.00			343 Oakland
ELLIS VOCATIONAL SVCS	2505		\$4,550.00		343 Oakland
EMPLOYMENT RESOURCE NETWORK	2505		\$4,680.00		348 Portland
EMPLOYMENT RESOURCES GROUP	2506			\$56,160.00	351 Muskegee
ENGLAND & CO REHAB SVCS INC	2505		\$3,848.00		328 Chicago
ENGLAND & CO REHAB SVCS INC	2506			\$36,433.74	328 Chicago
EVANSVILLE GOODWILL INDS INC	2505		\$22,335.00		326 Indianapolis
EVANSVILLE GOODWILL INDS INC	2506			\$700.00	326 Indianapolis
EVERGREEN HOSP HEAD INJURY	2504	\$1,690.00			346 Seattle
FAMILY PACIFIC	2505		\$2,500.00		459 Honolulu
FLOYD & ASSOCS LLC	2504	\$25,858.00			346 Seattle
FOSTER ASSESSMENT CTR	2504	\$32,805.00			344 Los Angeles
FOSTERS ASSES AND TESTING CTR	2504	\$27,335.00			344 Los Angeles
FRESH START REHAB	2504	\$24,950.00			317 St. Petersburg
FRESH START REHAB	2505		\$95,200.30		317 St. Petersburg
G E DEANER PHD CRC	2504	\$4,600.00			343 Oakland
GENERAUX BUSINESS CONSULTANTS	2504	\$1,625.00			354 Reno
GENEX	2504	\$13,655.00			328 Chicago
GENEX	2504	\$57,115.00			339 Denver
GENEX	2504	\$1,950.00			442 Cheyenne
GENEX	2505		\$29,230.00		328 Chicago
GENEX	2505		\$15,520.00		348 Portland
GENEX	2505		\$6,700.00		362 Houston
GENEX	2506			\$2,165.65	328 Chicago
GENEX SERVICES INC	2504	\$1,008.00			343 Oakland
GENEX SERVICES INC	2505		\$2,450.00		362 Houston
GEORGE MOORE & ASSOCS INC	2504	\$43,011.00			313 Baltimore
GEORGE MOORE & ASSOCS INC	2504	\$71,674.00			372 Washington
GEORGE MOORE & ASSOCS INC	2505		\$30,604.00		372 Washington
GEORGE MOORE & ASSOCS INC	2506			\$3,307.00	313 Baltimore
GEORGE MOORE & ASSOCS INC	2506			\$5,433.00	372 Washington
GLAPION COUNSELING & CONSULT	2504	\$6,480.00			343 Oakland

Vocational Rehabilitation and Employment Service
 Listing of Contractor Expenditures for FY 2004
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
GOODWILL INDS OF CENTRAL IN	2506			\$6,350.00	326 Indianapolis
GOODWILL INDS OF KYOWVA	2504	\$550.00			315 Huntington
GOODWILL INDS OF MIDDLE TN INC	2504	\$760.00			320 Nashville
GOODWILL INDS OF MIDDLE TN INC	2505		\$2,812.00		320 Nashville
GOODWILL INDS OF MIDDLE TN INC	2506			\$1,596.00	320 Nashville
GOODWILL INDS OF NE IN INC	2504	\$0.20			326 Indianapolis
GOODWILL INDS OF NE IN INC	2505		\$29,422.94		326 Indianapolis
GOODWILL INDS OF NE IN INC	2506			\$4,294.47	326 Indianapolis
GOODWILL INDS OF SPRINGFIELD	2504	\$1,250.74			301 Boston
GRAMS & ASSOCS	2504	\$200.00			343 Oakland
GRAMS & ASSOCS	2505		\$650.00		343 Oakland
HASKINS REHAB SVCS	2505		\$330.00		343 Oakland
HOUCK LIMITED	2504	\$14,541.00			315 Huntington
HOUCK LIMITED	2504	\$41,952.00			325 Cleveland
HOUCK LIMITED	2505		\$4,028.00		315 Huntington
HOUCK LIMITED	2505		\$27,252.00		325 Cleveland
HOUCK LIMITED	2506			\$1,500.00	315 Huntington
HOUCK LIMITED	2506			\$432.00	325 Cleveland
HU ANI & ASSOCS	2504	\$22,975.00			329 Detroit
HUFFY SERVICE FIRST	2506			\$542.50	325 Cleveland
HUGO ROMAN MD	2504	\$26,080.00			355 San Juan
HUMAN SVCS OUTCOMES INC	2504	\$7,690.00			317 St. Petersburg
HUMAN SVCS OUTCOMES INC	2504	\$65,208.00			340 Albuquerque
I N K VOCATIONAL COUNSELING	2504	\$9,050.00			343 Oakland
INTERMOUNTAIN WEST REHAB	2504	\$3,744.00			339 Denver
INTL CTR FOR THE DISABLED	2504	\$88,025.00			306 New York
INTL CTR FOR THE DISABLED	2505		\$25,650.00		306 New York
INTL CTR FOR THE DISABLED	2506			\$350.00	306 New York
INTRACORP	2505		\$21,024.00		348 Portland
INTRACORP	2506			\$7,811.15	318 Winston-Salem
INTRACORP INC	2504	\$5,629.00			335 St. Paul
INTRACORP INC	2505		\$4,331.09		335 St. Paul
INTRACORP INC	2505		\$5,376.00		348 Portland
INTRACORP INC	2506			\$685.00	318 Winston-Salem
INTRACORP INC	2506			\$1,936.00	335 St. Paul
IRA H COMBS EDD	2504	\$61,380.00			328 Chicago
IRA H COMBS EDD & ASSOCS	2505		\$1,665.00		327 Louisville
IRA H COMBS EDD & ASSOCS	2504	\$310.00			320 Nashville
IRA H COMBS EDD & ASSOCS	2504	\$32,210.00			328 Chicago
IRA H COMBS EDD & ASSOCS	2505		\$7,335.00		327 Louisville
IRA H COMBS EDD & ASSOCS	2505		\$150.00		328 Chicago
J MAGROWSKI PHD	2505		\$1,350.00		331 St. Louis
J R FLETCHER CONSULTING	2506			\$2,125.00	460 Wilmington
J SCOTT LANKFORD	2504	\$21,600.00			322 Montgomery
JAMES B ADAMS	2504	\$2,470.00			320 Nashville
JAMES B ADAMS & ASSOC INC	2504	\$9,610.00			319 Columbia
JAMES B ADAMS & ASSOC INC	2504	\$3,720.00			328 Chicago

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Listing of Contractor Expenditures for FY 2004
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
JAMES B ADAMS ASSOC INC	2504	\$57,030.00			319 Columbia
JAMES B ADAMS ASSOC INC	2504	\$52,480.00			328 Chicago
JAMES B ADAMS ASSOC INC	2505		\$310.00		319 Columbia
JAMES B ADAMS ASSOC INC	2505		\$310.00		328 Chicago
JAY KIND PHD	2504	\$1,125.00			309 Newark
JEREMY R THAYER	2505		\$775.00		313 Baltimore
JEWISH VOCATIONAL SVC	2504	\$4,284.00			331 St. Louis
JOB READY INC	2506			\$2,000.00	463 Anchorage
JOBS PLUS INC	2506			\$19,500.00	330 Milwaukee
JOCELYN LANGREHR MS	2504	\$550.00			460 Wilmington
JOHNSON & SPAVENTA	2504	\$82,670.00			344 Los Angeles
JOSEPH G LAW JR	2504	\$35,500.00			322 Montgomery
JOSEPH G LAW JR	2506			\$150.00	322 Montgomery
K R BRADFORD	2506			\$1,200.00	320 Nashville
K TREXLER ELLINGTON PHD	2504	\$6,175.00			341 Salt Lake City
K WHITE	2504	\$4,800.00			442 Cheyenne
KELLI BOWSER	2505		\$26,720.76		311 Pittsburgh
KELLY WHITE	2504	\$1,200.00			442 Cheyenne
KELLY WHITE	2505		\$600.00		442 Cheyenne
KITT MURRISON PHD	2504	\$600.00			343 Oakland
KRABACH INC	2504	\$500.00			339 Denver
L A HUEBNER PHD	2504	\$1,000.00			341 Salt Lake City
L BONURA	2506			\$1,000.00	362 Houston
LAURIE BARASH	2504	\$60.00			345 Phoenix
LAURIE BARASH	2506			\$861.00	345 Phoenix
LEARNING CENTER	2504	\$435.00			311 Pittsburgh
LINDA PARKER & ASSOC	2504	\$23,780.00			344 Los Angeles
LINDA S WALDROP OTR	2504	\$2,160.61			320 Nashville
LINDA S WALDROP OTR	2505		\$582.13		320 Nashville
LINK EMPLOY ABILITY POTENTIAL	2506			\$1,166.67	325 Cleveland
LISA B THOMAS	2504	\$900.00			322 Montgomery
LISA B THOMAS	2504	\$34,199.95			323 Jackson
LISA B THOMAS	2505		\$4,987.00		322 Montgomery
LISA B THOMAS	2506			\$3,375.00	322 Montgomery
LOS AMIGOS RESEARCH &	2504	\$605.00			343 Oakland
M C HARDSOCG	2504	\$5,500.00			442 Cheyenne
M C HARDSOCG	2506			\$550.00	442 Cheyenne
M L STINSON & ASSOCS	2505		\$3,900.00		343 Oakland
M V R CONSULTING SERVICES INC	2504	\$53,625.00			438 Sioux Falls
MALCOLM D FARMER	2504	\$7,250.00			315 Huntington
MALCOLM D FARMER	2505		\$1,750.00		315 Huntington
MANAGED CARE NETWORK	2504	\$1,300.00			307 Buffalo
MANAGED CARE NETWORK	2505		\$71,970.00		307 Buffalo
MANAGED CARE NETWORK	2506			\$78,125.00	307 Buffalo
MANZANITA INC	2504	\$6,350.00			341 Salt Lake City
MARGARET SANCHEZ	2504	\$2,200.00			343 Oakland
MARK S SMASAL PHD	2504	\$800.00			341 Salt Lake City

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 Listing of Contractor Expenditures for FY 2004
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Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
MARY JO WHITE	2504	\$650.00			317 St. Petersburg
MARY JO WHITE	2505		\$75.00		317 St. Petersburg
MEMPHIS GOODWILL IND	2505		\$5,200.00		320 Nashville
MERS MISSOURI GOODWILL INDS	2504	\$455.00			331 St. Louis
MERSMAN & SMITH VOCATIONAL	2504	\$4,000.00			343 Oakland
MICHAEL A FRANK & ASSOCS	2504	\$4,410.00			343 Oakland
MICHAEL A FRANK & ASSOCS	2505		\$2,400.00		343 Oakland
N HUGHES	2506			\$7,450.00	320 Nashville
N R V VENTURES INC PS	2504	\$26,075.00			346 Seattle
NANCY HENDERSON & ASSOCS INC	2504	\$124,095.00			344 Los Angeles
NANCY HENDERSON & ASSOCS INC	2505		\$355.00		344 Los Angeles
NANCY HENDERSON & ASSOCS INC	2506			\$660.00	344 Los Angeles
NATHALIE GENDRON LLC	2504	\$22,272.50			372 Washington
NATHALIE GENDRON LLC	2505		\$435,019.00		372 Washington
NATHALIE GENDRON LLC	2506			\$5,850.00	372 Washington
NELSON & ASSOCS REHAB SERVICES	2504	\$798.00			354 Reno
NEW CURATIVE REHAB INC	2506			\$3,000.00	330 Milwaukee
NEWAY DIRECTIONS	2506			\$1,800.00	330 Milwaukee
NORTHCOAST RESOURCE PARTNERS	2504	\$4,760.00			325 Cleveland
NORTHCOAST RESOURCE PARTNERS	2505		\$175.00		325 Cleveland
NORTHERN COLORADO VOCATIONAL	2504	\$5,500.00			442 Cheyenne
O S C VOCATIONAL SYSTEMS INC	2504	\$16,568.84			346 Seattle
OPPORTUNITIES & SOLUTIONS INC	2504	\$12,580.00			316 Atlanta
OPPORTUNITIES & SOLUTIONS INC	2504	\$105.00			317 St. Petersburg
OPPORTUNITIES & SOLUTIONS INC	2505		\$127,551.80		317 St. Petersburg
OPPORTUNITIES & SOLUTIONS INC	2506			\$890.00	317 St. Petersburg
P D M CONSULTING INC	2504	\$325.00			325 Cleveland
P D M CONSULTING INC	2505		\$57,028.50		325 Cleveland
P LG TAIMANGLO PHD	2504	\$10,050.00			459 Honolulu
PADILLA INVESTIGATIONS & CONS	2504	\$2,450.00			347 Boise
PARTNERS IN PLACEMENT INC	2506			\$3,772.00	320 Nashville
PECKHAM INC	2504	\$425.00			329 Detroit
PIONEER REHAB INC	2504	\$198,487.50			316 Atlanta
PIONEER REHAB INC	2505		\$365.00		316 Atlanta
PLACEMENT OPPORTUNITIES	2506			\$2,700.00	330 Milwaukee
PROCURA MGMT INC	2504	\$600.00			460 Wilmington
PROF REHABILITATION MGMT INC	2505		\$6,560.00		328 Chicago
PROFESSIONAL CONSULTING SVCS	2505		\$11,054.70		348 Portland
PROGRESSIVE REHAB SVCS INC	2504	\$9,000.00			339 Denver
PROGRESSIVE REHAB SVCS INC	2505		\$14,968.75		339 Denver
PROGRESSIVE VOCATIONAL SVCS	2504	\$7,600.00			315 Huntington
PROGRESSIVE VOCATIONAL SVCS	2506			\$3,000.00	315 Huntington
R B FRANCE PHD	2504	\$6,210.43			341 Salt Lake City
R G TAYLOR	2504	\$525.00			341 Salt Lake City
R P DICKOW	2504	\$13,950.00			329 Detroit
R T W SERVICES INC	2504	\$2,115.00			329 Detroit
R W DETLING	2505		\$32,063.46		311 Pittsburgh

Vocational Rehabilitation and Employment Service
Listing of Contractor Expenditures for FY 2004
February 1, 2005

Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
R WRIGHT OPTIC	2505		\$390.00		313 Baltimore
REGL REHAB	2505		\$21,450.00		348 Portland
REHAB ADVISORS INC	2505		\$175,300.00		317 St. Petersburg
REHAB ADVISORS INC	2506			\$100.00	317 St. Petersburg
REHAB PERSPECTIVES INC	2504	\$4,026.66			313 Baltimore
REHAB PERSPECTIVES INC	2504	\$1,890.00			314 Roanoke
REHAB PERSPECTIVES INC	2504	\$3,825.00			372 Washington
REHAB PERSPECTIVES INC	2505		\$425.00		372 Washington
REHAB SERVICES UNLIMITED	2504	\$28,420.00			313 Baltimore
REHAB SERVICES UNLIMITED	2506			\$200.00	313 Baltimore
REHAB SPECIALISTS GROUP INC	2504	\$7,843.50			345 Phoenix
REHAB SPECIALISTS GROUP INC	2505		\$5,132.50		345 Phoenix
REHAB SPECIALISTS GROUP INC	2506			\$1,020.00	345 Phoenix
REHAB TEAM ASSOCS INC	2504	\$67,275.00			329 Detroit
REHAB TEAM ASSOCS INC	2505		\$325.00		329 Detroit
REHAB TEAM ASSOCS INC	2506			\$2,600.00	329 Detroit
RESOURCE CONSULTANTS INC	2504	\$834.00			317 St. Petersburg
RESOURCE CONSULTANTS INC	2505		\$280.00		317 St. Petersburg
RESULTS & ASSOCS	2506			\$29,750.00	313 Baltimore
RICARDO AGUAYO	2504	\$300.00			327 Louisville
RINLY R GECOSALA MD PC	2504	\$325.00			345 Phoenix
RIPP REHAB INC	2504	\$900.00			345 Phoenix
RONALD L ROSENBERG PHD	2504	\$26,160.00			309 Newark
RSVP INC	2504	\$13,742.00			314 Roanoke
RTW VOCNL REHAB SERV	2504	\$25,895.00			325 Cleveland
RTW VOCNL REHAB SERV	2504	\$1,050.00			329 Detroit
RTW VOCNL REHAB SERV	2505		\$83,592.00		325 Cleveland
RTW VOCNL REHAB SERV	2506			\$26.00	325 Cleveland
S B SCHMIDT	2504	\$2,000.00			343 Oakland
S B SCHMIDT	2505		\$9,500.00		343 Oakland
S G KREUTER	2504	\$1,008.00			321 New Orleans
S J JENSEN	2504	\$12,400.00			339 Denver
S J JENSEN	2505		\$71,894.00		339 Denver
S J JENSEN	2506			\$332.00	339 Denver
SANDRA A POLIAKOFF	2504	\$14,800.00			316 Atlanta
SARAH J JENSEN	2504	\$8,870.00			339 Denver
SARAH J JENSEN	2505		\$38,429.00		339 Denver
SARAH J JENSEN	2506			\$415.00	339 Denver
SCHMIDT VOCATIONAL SERVICES LL	2504	\$21,500.00			437 Fargo
SEQUITY	2505		\$990.00		345 Phoenix
SEYLER FAVALORO LTD	2504	\$20,430.00			321 New Orleans
SISKIN HOSP FOR PHYSICAL REHAB	2504	\$500.00			320 Nashville
SOMERS VOCATIONAL GUIDANCE	2504	\$53,530.00			344 Los Angeles
SOUTHERN ILLINOIS UNIV	2504	\$1,995.00			328 Chicago
STONEBRIDGE REHAB	2505		\$78,422.50		348 Portland
STUBBE & ASSOCS	2504	\$46,293.00			334 Lincoln
STUBBE & ASSOCS	2505		\$1,818.00		334 Lincoln

ATTACHMENT D

Vocational Rehabilitation and Employment Service
 Listing of Contractor Expenditures for FY 2004
 February 1, 2005

Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
STUBBE & ASSOCS INC 5082	2504	\$34,408.06			335 St. Paul
STUBBE & ASSOCS INC 5082	2506			\$4,300.00	335 St. Paul
T YOUNG	2504	\$20,750.00			325 Cleveland
T YOUNG	2504	\$625.00			326 Indianapolis
T YOUNG	2505		\$13,233.00		326 Indianapolis
TERRILL & ASSOCS INC	2504	\$12,705.00			452 Wichita
TIM W FICKLIN	2504	\$40,580.00			351 Muskogee
TIM W FICKLIN	2505		\$300.00		351 Muskogee
TIRR GROUP INC	2504	\$173,483.00			377 San Diego
TIRR GROUP INC	2505		\$2,260.00		377 San Diego
TOTAL VOCATIONAL SERVICES	2504	\$7,621.00			346 Seattle
TOURO INFIRMARY	2504	\$6,359.00			321 New Orleans
TOURO INFIRMARY	2506			\$220.00	321 New Orleans
TRAC ASSOCS INC	2504	\$18,260.00			346 Seattle
TRAC ASSOCS INC	2505		\$156,530.00		346 Seattle
TRI AREA REHAB SVCS INC	2504	\$26,250.00			313 Baltimore
TRI AREA REHAB SVCS INC	2504	\$750.00			314 Roanoke
TRI AREA REHAB SVCS INC	2504	\$4,500.00			372 Washington
TRI AREA REHAB SVCS INC	2506			\$800.00	313 Baltimore
UNIV OF WISCONSIN	2506			\$8,700.00	330 Milwaukee
VANGUARD CAREER SVS	2506			\$5,690.00	306 New York
VANGUARD CAREER SVS	2506			\$19,060.00	309 Newark
VERMEER REHAB SERVICES	2504	\$86,470.00			339 Denver
VERMEER REHAB SERVICES	2504	\$3,510.00			442 Cheyenne
VERMEER REHAB SERVICES	2505		\$585.00		339 Denver
VESSELL VOC SVCS	2504	\$1,500.00			320 Nashville
VESSELL VOC SVCS	2504	\$500.00			322 Montgomery
VESSELL VOC SVCS	2505		\$500.00		320 Nashville
VESSELL VOC SVCS	2505		\$6,300.00		322 Montgomery
VESSELL VOC SVCS	2506			\$59,700.00	320 Nashville
VESSELL VOC SVCS	2506			\$975.00	322 Montgomery
VICKIE PRATTON MS	2504	\$20,900.00			322 Montgomery
VICKIE PRATTON MS	2505		\$550.00		322 Montgomery
VICTORIA A SAUNDERS	2505		\$34,975.00		362 Houston
VISION INTEGRATED PROGRAMS	2504	\$17,824.99			321 New Orleans
VISION INTEGRATED PROGRAMS	2505		\$62.50		321 New Orleans
VISION INTEGRATED PROGRAMS	2506			\$470.00	321 New Orleans
VOCATIONAL DESIGNS INC	2504	\$3,520.00			343 Oakland
VOCATIONAL DESIGNS INC	2504	\$3,195.00			344 Los Angeles
VOCATIONAL DESIGNS INC	2505		\$10,665.00		343 Oakland
VOCATIONAL MANAGEMENT	2504	\$52,800.00			463 Anchorage
VOCATIONAL SERVICES INC	2504	\$44,145.00			463 Anchorage
VOCWORKS	2504	\$690.00			326 Indianapolis
VOCWORKS	2505		\$5,950.00		326 Indianapolis
VOCWORKS LTD	2505		\$5,808.00		326 Indianapolis
WELLNESS INSTITUTE INC	2504	\$23,795.00			321 New Orleans
WKU RESEARCH FDN INC	2505		\$17,940.00		327 Louisville

ATTACHMENT D

Vocational Rehabilitation and Employment Service
 Listing of Contractor Expenditures for FY 2004
 February 1, 2005

Vendor Name	BOC	Amount paid in FY 2004 for BOC 2504	Amount paid in FY 2004 for BOC 2505	Amount paid in FY 2004 for BOC 2506	RO
XPERT PLACEMENT LLC	2506			\$4,500.00	330 Milwaukee
YANO REHAB INC	2504	\$1,300.00			313 Baltimore
YANO REHAB INC	2504	\$5,125.50			315 Huntington
YANO REHAB INC	2504	\$12,238.05			372 Washington
YANO REHAB INC	2505		\$8,869.00		313 Baltimore
YANO REHAB INC	2505		\$1,780.00		372 Washington
YANO REHAB INC	2506			\$919.80	313 Baltimore
TOTALS		\$4,090,574.49	\$2,533,814.28	\$441,861.96	

QUESTIONS FOR THE RECORD

Congresswoman Darlene Hooley

Question #2

Secretary Nicholson,

I've received a number of complaints about the long waiting lists at the Portland VA. Most recently, I received a letter from a staff member at the Portland VA Medical Center who told me that the center has a waiting list of over 500 patients just for orthopedic surgery and this list is growing daily. Some patients are being told that they will now have to wait at least an additional 24 months before they can get their surgeries. This is unacceptable. What is the VA doing to address this situation and make sure that these veterans get the surgeries they need in a timely manner?

**QUESTIONS FOR SECRETARY NICHOLSON FROM
CONGRESSWOMAN STEPHANIE HERSETH
VETERANS AFFAIRS BUDGET COMMITTEE HEARING
FEBRUARY 15, 2005**

Appeals

1. Although the number of appeals pending has almost doubled in the past four years, there is no indication of funding in the budget to address the increased appeals workload and especially those remanded claims which have been pending for years. What additional number of Full Time Employee Equivalents (FTEE) would be needed to reduce the number of remands pending for more than one year to less than 1,000 by the end of FY 2006?

Education Service

2. In the area of veterans' education benefits, the President's budget request would eliminate 14 full-time staff positions within the VA's Education Service. How do you justify this request?

As you know, education claims are expected to increase due to more veterans seeking to take advantage of the Montgomery G.I. Bill, as well as the new Chapter 1607 - Guard and Reserve education program enacted last year as part of the National Defense Authorization Act of 2005 (section 527 of the National Defense Authorization Act of 2005; Public Law 108-375).

Outpatient Clinics

3. Many veterans in my state of South Dakota must travel hundreds of miles in order to receive health care. These veterans depend heavily on VA outpatient clinics for their health care needs. Can you tell me how this budget will impact outpatient clinics?

In the long run - is the VA planning to increase the budget for outpatient clinics in order to build more facilities and increase access to health care for rural veterans? I hope this budget and future budgets reflect the need for more outpatient clinics.

There are ten outpatient clinics in South Dakota and 700 throughout the nation.

Women Veterans

4. As the number of women veterans seen at VA health care facilities continues to increase, I was hoping you could explain how the VA budget has changed to reflect the needs of a growing number of women patients. Example: Specialty programs for Sexual trauma and OB/GYN care.

PTSD

5. I have serious concerns regarding the Department of Veterans Affairs preparation and ability to deal with the influx of veterans that will be returning home from Afghanistan and Iraq with Post Traumatic Stress Disorder (PTSD). Do you feel the VA is adequately prepared to deal with these veterans – many of whom may not develop PTSD symptoms for many years?

The President's budget includes \$2.2 billion (an additional \$100 million over 2005) for mental health services.

Vocational Rehabilitation and Employment Program

6. As I'm sure you are aware, the number of veterans applying for vocational rehabilitation and employment services increased dramatically over the last decade – roughly 75 percent increase. Demand for this service will surely continue due to the many injuries suffered by our troops serving in Iraq and Afghanistan.

Recognizing the great importance of providing quality employment services to our transitioning disabled servicemembers, former Secretary Anthony J. Principi, established a task force to review the vocational rehabilitation and employment program (VR&E) from “top-to-bottom.” The VR&E Task Force issued a comprehensive report in May of 2004. The report contained 102 recommendations to improve the VR&E program and reform it to be responsive to 21st Century needs of service-connected disabled veterans.

The Task Force recommended an additional 228 full-time staff positions for the VR&E program: including 27 FTEE in headquarters; 112 in the regional offices to deliver direct services; 56 in the regional offices for contracting and purchasing; and 8 quality assurance staff.

The President's budget request does not provide any resources consistent with the VA's own VR&E Task Force report. Rather, the President's budget simply reflects a redistribution of “management support” personnel.

When does the administration plan to provide these necessary resources to the VR&E program?

Rep. Corvino Brown

#3
of 4**Question for Secretary Jim Nicholson**
Panel 1

VA is proposing to cut research programs again in fiscal year 2006. What percentage of merit-review projects is it currently able to fund? How will the funding request for FY 2006 impact the VA's ability to fund merit-reviewed projects?

Rep. Corvino Brown

#4
of 4**Question for Secretary Jim Nicholson**
Panel 1

Congress will soon consider a supplemental appropriation for sustaining military operations in Iraq and Afghanistan. Should any additional funding for VA health care be considered as a continuing cost of war?

Rep. Corrine Brown

#5
217

QUESTIONS:

MR. SECRETARY: CONSIDERING HOW MUCH THE PRESIDENT COURTED VETERANS IN LAST ELECTION, WHAT WAS THE THINKING IN THE LACK OF FUNDING FOR THE PROGRAMS THAT WILL MOST HELP VETERANS AND THE ALMOST UNANIMITY OF THE OPPOSITION FROM THE VETERAN SERVICE ORGANIZATIONS TO THE PRESIDENT'S BUDGET?

YOU ASK CONGRESS TO CHANGE ITS MIND AND ALLOW THE \$250 ANNUAL

Rep. Corrine Brown

#6
24

ENROLLMENT FEE FOR CATEGORY 7 AND 8 VETERANS, YET YOU DO NOTHING ON YOUR END BY ALLOWING 7 AND 8 VETERANS TO ENROLL IN THE VA SYSTEM. IF THE FEE IS SUCH A GOOD IDEA, WHY NOT OPEN THE VA TO ALL VETERANS?

WHY IS THIS ADMINISTRATION NOT PUTTING ALL ITS RESOURCES INTO BUILDING CENTERS FOR THE LARGE NUMBER OF VETERANS RETURNING FROM CENTRAL ASIA AND ELIGIBLE FOR VA CARE? THE CARES PROGRAM IS NOT

Rep Corrine Brown

7
24

FUNDED NEAR WHAT THIS
ADMINISTRATION PROMISED WHEN IT
UNDERTOOK THIS CONSOLIDATION
PROGRAM.

Rep. Ted Strickland
February 16, 2005
HVAC Hearing
Questions for Secretary Nicholson

POW Question:

1. Mr. Secretary, a law sponsored by Bob Dole and co-sponsored by Orrin Hatch and Strom Thurmond (PL104-132) authorizes US victims of terrorism and torture to sue state sponsors of terrorism. Should US soldiers - now veterans – who were captured and tortured in Iraq in the first Gulf War be prohibited from seeking compensation for being illegally tortured?

WWII Chemical Veterans Question:

1. Mr. Secretary, earlier this month I sent you a letter requesting an update on the VA's efforts to contact those WWII veterans who were exposed to mustard gas, Lewisite, and nerve agents, and are surviving today, but may be suffering from cancer, diseases, and permanent injuries related to their service. In the past the VA had promised to conduct outreach to these men, but not a single veteran was contacted. Under your leadership, what is the VA going to do to contact and treat these veterans?

Oversight Questions:

1. Mr. Secretary, I have a series of questions regarding the savings estimate that you base on management efficiencies. How confident are you in this \$1.8 billion "subtraction" from the budget? After all, if your Administration does not deliver – veterans will be short changed by almost 2 billion dollars – would you call that significant?
2. Mr. Secretary, in the FY 2004 Budget Submission, VA estimated management savings of \$950 million to partially offset the overall cost of health care. If VA did not anticipate savings through management efficiencies, VA would have likely received almost one billion dollars more for veterans health care. That estimate was accepted at face value and was based on implementation of a rigorous competitive sourcing plan, reforming health care procurement, increasing employee productivity, shifting from inpatient to outpatient care, reducing employee travel, interagency motor pools, maintenance and repair services, and operating supplies. Now that FY 2004 is behind us, we should be able to look back and assess the accuracy of that estimate. Do you agree?
3. In April 2003 VA General Counsel determined that VHA had limitations in law preventing a robust competitive sourcing plan. In FY 2004 VHA did almost no competitive sourcing, a principal basis for the savings estimate – although even

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the assertion that competitive sourcing saves money over the long-term is suspect. However, the fact that there was no competitive sourcing would impact the estimate, would it not Mr. Secretary?

The 2004 estimate also speaks to health care procurement, but the IG has found over 25 million in pre and post award contract audits. Additionally, an audit of major construction contracts notes a VA risk for excessive prices in the \$133 million dollar range and notes potential fraud involving certain contract award actions. Do you think that these are the basis for the management efficiencies? It sounds like just the opposite to me.

4. A Nov. 4, 2004 independent audit by Deloitte and Touche noted that Operational Oversight in the VHA was a repeat condition requiring attention. The audit notes continued non-compliance with certain established policies and procedures important to maintain internal controls. How, Mr. Secretary, does that equate with being savings through management efficiencies?
5. The same Deloitte and Touche report, names the Integrated Financial Management System of VA once again as a Material Weakness -- a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. This is a repeat write-up. Does that sound like performance contributing to almost a billion dollars in management efficiency savings Mr. Secretary?
6. Mr. Secretary -- undoubtedly VA has management efficiencies that would pass muster. However, VA managers have also made some significant errors as well. Near the end of the 06 Budget Submission Summary, volume #4 of 4, about 7 printed pages from the end of this last document, we find mention of the failed Core FLS system. The write-up in your Budget does not mention the wasted quarter of a billion dollars in obligated funds for an unsuccessful system. This Administration's Budget does not mention bad project management of CoreFLS when it claims savings through management efficiencies. It only refers to "technology and other issues" as the reason to phase out the project. The VA IG's August 11, 2004 report is somewhat more succinct -- "VA's management of the CoreFLS project did not protect the interests of the government." If you wish to forecast and claim the successes, you must also accept responsibility for the failures. VA needs to prove its claims to management efficiencies BEFORE we count them against the budget requirements. This Administration essentially borrowed health care funds against its promise of management efficiencies, how will it repay the one billion dollars in missing funds to our veterans?

330AA

REPUBLICANS
STEVE BUYER, INDIANA, CHAIRMANDEMOCRATS
LANE EVANS, ILLINOIS, RANKING

U.S. House of Representatives

COMMITTEE ON VETERANS' AFFAIRS

ONE HUNDRED NINTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
<http://Veterans.house.gov>

February 22, 2005

Honorable James Nicholson
Secretary, Department of Veterans Affairs
810 Vermont Avenue
Washington, DC 20420

Mr. Secretary:

From Fiscal Years 2003 through 2006, the Department of Veterans Affairs (VA) Budget Submission has claimed over \$4.345 billion in savings through unproven management efficiencies and has used these projections of savings to offset veterans' health care funding. Proof of net savings through management efficiencies has yet to be demonstrated. Were those net savings to be proven, we would laud VA's successful management efforts. If they cannot be proven, the savings offset to veterans' health care should cease immediately because of the potential adverse impact on veterans' health care. No claim of savings through implemented management efficiencies should be acceptable *until* the net savings are proven when compared to a demonstrable baseline.

In past years VA, like most agencies, has demonstrated both management successes and mismanagement-related setbacks. The aggregate effect of those actions is not clear. What is clear is that veterans' health care funding has been reduced based on a claimed amount, rather than on the actual savings realized. This must stop.

I request VA expedite its proof of savings through management efficiencies for the period FY 2003-FY 2006. I would like you to include analysis related to the net impact of failures of the CoreFLS and HR Link\$ systems, delays or failures of other major projects, and to also account for the impact of all Inspector General, Government Accountability Office and independent auditor findings related to management deficiencies. Finally, VA should review the testimony and materials submitted for the record

related to this Committee's hearings on Fraud, Waste, Abuse and Mismanagement at VA, and which were directed by the House Budget Committee in FY 2004.

As VA has adjusted this savings estimate in each of the last three budget submission cycles, it follows that data should be available to support all prior projections and changes. Please provide that data and analysis to the Subcommittee on Oversight and Investigation before March 17, 2005.

Thank you for your prompt action.

A handwritten signature in cursive script, reading "Lane Evans", written over a horizontal line.

Lane Evans

Ranking Member, House Veterans' Affairs Committee

A handwritten signature in cursive script, reading "Ted Strickland", written over a horizontal line.

Ted Strickland

Ranking Member, Subcommittee on Oversight and Investigation



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
March 25, 2005

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

This is in response to your letter jointly signed by Congressman Ted Strickland regarding management efficiencies. The Department of Veterans Affairs (VA) has been very aggressive during the last few years in implementing a variety of initiatives that continue to improve the efficiency with which we provide health care to our Nation's veterans.

During FY 2003 and FY 2004, VA achieved actual management savings in excess of the estimates included in the budget requests for those 2 years. In FY 2003, our management efficiencies totaled over \$627 million, or nearly double the amount projected in the budget. Last year our savings reached in excess of \$649 million, or 2 percent more than the budget estimate. The majority of these management savings are the result of implementing numerous procurement reforms, particularly standardization related to the purchase of pharmaceuticals. The Department has also realized significant efficiencies due to standardization of other supplies, materials, and equipment; administrative consolidations; and increased sharing with the Department of Defense.

Our recent success in achieving management savings beyond those projected in the budget have been documented by the Government Accountability Office (GAO) in a review released in early March titled, "Budget Justification Issue Papers on Fiscal Year 2006, Department of Veterans Affairs' Medical Care Collections Fund and Management Efficiencies." Not only did GAO attest to the efficiencies VA actually realized during the last 2 years, but based on our past performance, GAO believes our estimate of \$590 million in management savings for FY 2006 appears achievable.

Part of our continuing focus on maximizing the level of management efficiencies will be the implementation of improved contracting practices with medical schools and other VA affiliates for scarce medical specialties. This is a long-standing issue for which the Department is aggressively implementing management changes to ensure fair pricing for the services provided by our affiliates. VA will continue to explore additional opportunities to improve the efficiency of our health care delivery system.

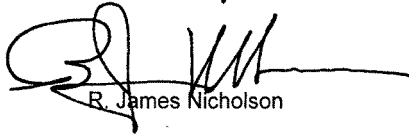
Page 2.

The Honorable Lane Evans

I appreciate your ongoing commitment to veterans and look forward to working with you to ensure that our former servicemen and women who have given so much to this country in defense of freedom around the world are provided the very best in health care and benefits.

A similar letter has been sent to Congressman Strickland.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'R. James Nicholson'. The signature is stylized with a large, looped initial 'R' and a series of vertical strokes for the name 'Nicholson'.

R. James Nicholson

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<http://veterans.house.gov>

April 13, 2005

Honorable R. James Nicholson
 Secretary
 Department of Veterans Affairs
 Washington, DC 20420

Dear Mr. Secretary:

We ask that you be more responsive to our request for a detailed accounting of VA's net management efficiencies. Your response of March 25, 2005, actually raises far more questions than it answers.

The Department's response failed to offset what we believe may be the elucidation of genuine management efficiencies with numerous, well-documented management problems. Our initial letter listed several of these "problems" which the Department's March 25th response conveniently overlooked. Many of the issues cited as efficiencies in your response are actually identified in VA Inspector General (IG) and Government Accountability Office (GAO) reports as problem areas.

The Department claims management efficiencies in FYs 2003-04 beyond the amount projected for that year's budget. Unfortunately, a baseline is never provided, nor is any evidence of net achievement for the agency.

The GAO issue paper cited in your reply indicates the potential for more savings through increased resource sharing, but its author did not consider management problems to determine the net efficiencies at VA. It is a little like a poker player only counting the hands she wins and never counting the losses. The ledger must be balanced – it is the total performance that matters.

Mr. Secretary, it is our view that correcting a management deficiency only returns management to where it should have been in the first place. Creating true management efficiency entails growing a system that is already functioning

Honorable R. James Nicholson
April 13, 2005
Page 2

properly and is free of defects to achieve measurable results that are greater than would otherwise be expected. Virtually every item you cite in your response as an area primed to be a management efficiency is also identified as somehow deficient, in whole or in part, by either the IG or GAO.

For example, since February 2005 the VA IG has reported problems with: Federal Energy Management Compliance (Report# 04-00986101), VHA Sole-Source Contracts With Medical Schools and Other Affiliated Institutions (05-01318-85), and VBA Vocational Rehabilitation and Employment Contracts. Earlier projections of VA management efficiencies in finance, logistics and supply springing from information technology advances were likely lost when the CoreFLS program failed. Similar lost efficiency opportunities followed the demise of VA's HR LINK\$ system.

Please provide an accounting of VA management efficiencies that is both detailed and provable against a clear baseline. We ask that you take a total view of management and not just count the "winning hands."

Sincerely,



LANE EVANS
Ranking Democratic Member



TED STRICKLAND
Ranking Democratic Member
Subcommittee on Oversight
and Investigations



★ NATIONAL HEADQUARTERS ★ PO BOX 1055 ★ INDIANAPOLIS, INDIANA 46208-1055 ★



February 22, 2005

(317) 636 8411 ★

For God and Country

Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

In response to your request to provide the House Veterans' Affairs Committee with the details and descriptions of the methodology used to develop The American Legion's Department of Veterans' Affairs (VA) Fiscal Year 2006 funding recommendation of \$34.1 billion for veterans' health care, I submit the following description of the assumptions used to project the resources that will be required to provide care to those veterans who are expected to use the VA health care system. The American Legion hopes you will find the information provided informative and useful in restoring the budgetary shortfall in the President's budget request.

Traditionally, we start with Office of Management and Budget's (OMB's) "spring guidance" to all Federal budget offices. For the most part, this "guidance" is budget-driven rather than needs based, especially with regard to VA. This guidance came well before the final VA appropriations were made for fiscal year 2005. As an example, the May 2004 "guidance" provided the following recommendations for the fiscal year 2005 request:

- Medical Care Collections Fund – \$281 million through enrollment fees (increase \$13 million).
- Medical Care Collections Fund – \$145 million through increased first-party collections (increase of \$7 million).
- Medical Care Collections Fund – \$9 million through long-term care collections (freeze).
- Medical Care Collections Fund -- \$1.089 billion through other third-party collections (increase of \$52 million).
- Medical and Prosthetic Research – \$750 million (decrease \$20 million).
- Medical Care -- \$28.745 billion (decrease \$726 million).

We also consider VA's Office of the Assistant Secretary for Management's fiscal year 2005 Budget Submission as well. This publication provides a thorough overview of the entire VA budget. Although this document fails to reflect the "true" budgetary needs of VA and we disagree with many of the VA legislative initiatives contained therein, it provides an alternative perspective when developing the budget recommendations submitted by The American Legion.

Honorable Steve Buyer, Chairman
February 22, 2005
Page 2

The prior fiscal year final budget approved by Congress is also taken into consideration. Due to the fact that in recent years, the final budget is not determined until late into the next fiscal year, this is becoming more difficult to use and is a less reliable resource.

The American Legion collects a great deal of information through visits to VA health care facilities and first hand accounts from VA personnel and VA patients as well. We have shared much of this information with VA and Congress through congressional testimony, as well as our Annual assessment of VA- *A System Worth Saving: A Special Report on the Condition of VA Health Care in America*.

Additionally, many of our staff and volunteers serve on government advisory committees. Through these efforts, we gain tremendous insight and information on the needs of VA – officially and unofficially. An excellent example is the service of National Adjutant Robert W. Spanogle, who served as a Commissioner on the *President's Task Force to Improve Health Care Delivery for Our Nation's Veterans*. His involvement in this Committee provided insight into the improvements needed within the VA health care system.

The American Legion's assumptions and recommendations are based on the qualitative and quantitative information collected from these many official and unofficial sources.

For Fiscal Year 2005, following a continuing resolution, VA received an appropriation of \$29.98 billion. In our fiscal year 2005 budget request, we proposed \$30 billion; the Administration's request was \$26.7 billion. Both requests were exclusive of collections.

This year, The American Legion applied the highest of the past five-year Bureau of Labor Statistics' medical inflation rates of 5.0 percent (2002) to the fiscal year 2005 recommendation, then added the projected \$2.16 billion in third-party collections. Given VA's track record at collections, we then added an additional \$150 million to arrive at the \$34.1 billion we proposed to the Committee last week for fiscal year 2006.

I hope I have addressed all of your concerns and as always, we look forward to working with you and your staff in the best interest of America's veterans and their families.

With warmest regards and on behalf of The American Legion, I am,

Sincerely Yours,



Peter S. Gaytan, Director
Veterans Affairs and
Rehabilitation Commission

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

www.independentbudget.org

March 25, 2005

Honorable Michael Bilirakis, Vice Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Representative Bilirakis:

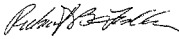
On behalf of *The Independent Budget*, we would like to thank you for the opportunity to present our views on the FY 2006 budget for veterans' health care. Only through cooperation between the veterans service organizations and the members of the Committee can we hope to attain an adequate level of funding to provide timely quality health care.

We have included with our letter a response to each of the questions that you presented following the hearing on February 16, 2005. Thank you very much.

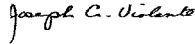
Sincerely,



Rick Jones
National Legislative Director
AMVETS



Richard B. Fuller
National Legislative Director
Paralyzed Veterans of America



Joseph A. Violante
National Legislative Director
Disabled American Veterans



Dennis Cullinan
National Legislative Director
Veterans of Foreign Wars
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Question 1 – The Subcommittee received a letter dated February 11, 2005, from Deputy Secretary Gordon Mansfield stating that VETSNET would again be delayed from December 2005 to December 2006. This initiative is going on 12 years now at a cost of \$400 to \$500 million and still is not deployed. In light of this, do you believe an additional \$12 million is justified for the VETSNET program for 2006?

Answer: Like many other Federal agencies, the Department of Veterans Affairs (VA) has had problems with developing and deploying an integrated information system that matches its business processes. Regardless, modern information systems are essential to the efficient and effective administration of VA's massive benefit programs. For the funding of the VETSNET subsystems addressed in *The Independent Budget*, the President's budget apparently includes no money. We doubt that the omission of recommendations for funding of these information technology initiatives in the budget has anything to do with the utility or appropriateness of these systems, but we believe instead that it is purely budget driven. Accordingly, we believe that an additional \$12 million is justified for VETSNET.

Question 2 – In your testimony you strongly state your support for the development of an electronic medical record that is interoperable and allows bidirectional exchange of health information and occupational and environmental exposure data. You also stated that this should include an easily transferable electronic form DD214 (Certificate of Discharge from Active Duty). This would allow VA to expedite the claims process and give the service member faster access to health care and benefits. Do you believe that today's technology can address this issue? What do you think this Committee should do to ensure that VA and DOD achieve this goal?

Answer: *The Independent Budget* believes that the technology does exist to implement the recommendations that we have made. In fact, the Department of Defense (DOD) already has the capability to provide an electronic version of the DD214 to the VA. It is also working to improve the electronic format of this form.

Additionally, in February 2005, DOD and VA provided a demonstration at the 2005 Annual Healthcare Information and Management Systems Society (HIMSS) Conference & Exhibition. Specifically, the Bidirectional Health Information Exchange at the Cross-Enterprise Interoperability Showcase depicted that two distinct healthcare systems can securely share patient information in an effort to improve the quality and safety of healthcare delivery.

Previously, the project to develop a government computer-based patient record lacked a lead entity and clear mission. Furthermore, detailed planning to achieve that mission made it difficult to monitor progress, identify project risks, and develop appropriate contingency plans. Currently, both agencies have agreed to designate the VA as the lead entity for the initiative, as well as re-evaluate and revise its original goals and objectives, and assign a full-time project manager and supporting staff to oversee its implementation.

Leadership within VA and DOD have created an implementation plan, the Joint Electronic Health Records Plan signed by the VA Under Secretary for Health and the DOD Assistant Secretary of Defense for Health Affairs, which contains a strategy to ensure that interoperable data repositories are developed, jointly-adopted standards are implemented into health systems, and interoperable health software applications are developed or acquired by the agencies. This Plan is jointly managed at the executive and project levels within each agency.

We believe that the most important role of the Committee to ensure that DOD and VA achieve this goal is aggressive oversight. Following the March 17, 2004, hearing conducted by the House Veterans' Affairs Subcommittee on Oversight and Investigations, GAO explained in its response to post hearing questions that they observed "the level of activity undertaken by the departments (DOD and VA) to support the initiative increased significantly in the month preceding the hearing."

The "National Defense Authorization Act for FY 2003" mandated that eight medical sites be designated for joint demonstrations through FY 2007 between VA and DOD medical facilities. These demonstrations were required to include cooperation in three separate areas: budget and financial management, staffing and assignment, and medical information and information technology systems. The medical information and information technology systems demonstration is specifically examined at three locations:

- Seattle/Tacoma area – between Madigan Army Medical Center and the Puget Sound VA Health Care System
- El Paso, Texas – between William Beaumont Army Medical Center and the El Paso VA Health Care System
- San Antonio, Texas – between at Air Force Wilford Hall and Brooke Army Medical Centers and the South Texas VA Health Care System.

However, these demonstration projects are only just getting started. The Committee must ensure that it conducts follow-up with the VA and DOD to assess these projects. Findings from these sites could better prepare the agencies for improving and implementing new information technology strategies down the road.

Moreover, P.L. 108-136, the "National Defense Authorization Act for FY 2004," established the Joint Executive Committee (JEC) between the DOD and VA. The JEC was charged with developing strategies for coordination and sharing between the two departments and implementing these strategies. The JEC is comprised of the Health Executive Committee and Benefits Executive Committee to assist with these requirements. The law also required the JEC to provide an annual report detailing what strategies have been developed and what steps have been taken to implement these strategies.

The Independent Budget is concerned that none of the actions taken by the JEC or the Health Executive Committee have been made public and that we have no real evidence of what they have done.

Question 3 – *The Independent Budget* recommends that the VA establish recruitment programs that enable VA to remain competitive with private sector marketing strategies to retain and recruit nursing staff. One of the best models available for recruitment and retention of nursing staff is the Magnet Recognition program, but *The Independent Budget* does not include this particular program in its recommendations. Does *The Independent Budget* support the Magnet Recognition program?

Answer: *The Independent Budget* believes that the Magnet Recognition program is in fact an excellent program, particularly when used to recruit nurses. The Department of Veterans Affairs testified in a hearing conducted by this Committee on October 2, 2003, that hospitals that have attained Magnet Recognition status have excellent patient outcomes and higher rates of nurse retention and job satisfaction. The American Nurses Association testified at the same hearing that patients treated at Magnet designated facilities experience lower mortality rates, shorter lengths of stay and increased satisfaction, while nurses working at these facilities have increased satisfaction, as well as increased perceptions of productivity and the quality of care given. All of these positive characteristics can only benefit VA as it attempts to hire more nurses.

However, we have some concerns about the VA's decision to gain Magnet Recognition status for its hospitals. Currently, the VA has a freeze on new hiring for nurses. If the Magnet Recognition program is intended to be a recruiting tool, we would like to know what the VA intends to do with this new status at its hospitals if it is not hiring. The cost and time associated with achieving this status would seem to be a waste if the VA will not be recruiting more nurses to fill its many vacancies. *The Independent Budget* would like some assurance from the VA that it will be bringing more nurses into the system as its hospitals become Magnet facilities.



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 8, 2005

The Honorable Steve Buyer
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Attached are the Department of Veterans Affairs' responses to the House Committee on Veterans' Affairs' hearing questions on the Department's budget for fiscal year 2006.

Please accept my apology for the delay in providing these responses to the Committee's post hearing questions, and my assurance that every effort will be made to ensure that this situation does not reoccur.

Please let me know if you require additional information.

Sincerely yours, •

A handwritten signature in black ink, appearing to read "R. James Nicholson". The signature is stylized with a large initial "R" and a long horizontal stroke.

R. James Nicholson

Enclosure

**Questions for the Record
Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
February 16, 2005**

**Hearing on Department of Veterans Affairs
Fiscal Year 2006 Budget**

Question 1: The Budget proposes adding 28 new community-based outpatient clinics (CBOCs) in FY 2006.

a. Has VA evaluated the need for these 28 CBOCs in light of the proposed cost sharing policies for enrollees in Priorities 7 and 8 in the FY 2006 Budget?

Response: There were 156 new community-based outpatient clinics (CBOC) identified for implementation by 2012 in the Secretary's CARES Decision published in May 2004. Veterans Health Administration (VHA) is currently moving forward with 13 CBOCs that are in various stages of implementation and 4 recently approved CBOCs. Further decisions about the implementation of additional CBOCs will be made as the year progresses and will take into account the organization's budget decisions and cost sharing policies.

b. What are the criteria VA uses to determine the need for a CBOC in any particular location?

Response: National planning criteria for new CBOCs are outlined in *VHA Handbook 1006.1 Planning and Activating Community Based Outpatient Clinics*. Business plans for proposed CBOCs are evaluated against the planning criteria which are updated annually. Currently, CBOC planning criteria target service to priority 1-6 veterans, minority veterans, and rural areas. CBOC planning criteria also give priority to new CBOCs that: reduce appointment waiting times and backlogs, take advantage of opportunities for VA/DoD joint ventures, and demonstrate linkages and consistency with approved CARES plans. Specific criteria that address the priority location of CBOCs are as follows:

- Distance of proposed site from existing VHA primary care sites (when addressing an identified access need) should be at least 30 minutes from an existing primary care site for urban and rural areas, and 60 minutes for highly rural and/or low population density areas. If the CBOC is proposed to address space deficits at a parent facility, the proposed site should be no more than 20 minutes from the parent facility serving existing users;
- Number of current Priority 1-6 users in the proposed market area (at least 1,300 users in a 3-year period);
- Priority 1-6 market penetration in the proposed market area is below 25 percent. Priority 1-6 veteran population of the market area for the proposed CBOC is greater than national average of 38 percent; and

- Unique considerations (geographic, demographic, etc.) such as: targeted minority veteran populations (e.g., Native Americans, African Americans, etc.), geographic barriers, highly rural and/or low population density (greater than 20 civilians per square mile), medically underserved or health manpower shortage area, Department of Defense (DoD) sharing opportunity, or parking and transit issues for sites proposed to address space deficits at parent facilities).

Question 2: What level of confidence does the Department have in its ability to achieve \$1.8 billion in management savings in FY 2006?

Response: VA is very confident that the \$1.8 billion in management savings can be achieved by the end of FY 2006 because it represents a 3-year accumulation of management savings from 2004 through 2006 or about 2 percent rate of improvement. VA used management efficiencies in the past and will continue to monitor and emphasize the need for performance that results in minimizing unit costs where possible, and eliminating inefficiency in providing quality health care. The \$1.8 billion in management efficiencies is composed of recurring and anticipated new efficiencies in standardizing pharmaceuticals and supplies, inventory management, productivity, and administrative/clinical consolidations and VA/DoD sharing.

Question 3: The Budget discusses several strategies VA is implementing to improve collections in the future, including centralized revenue operation centers. Will these centers be contracted out or staffed in house?

Response: VA currently plans for consolidated patient account centers to be staffed in-house.

Question 4: Are the collection estimates in FY 2006 Budget conservative or challenging?

Response: The FY 2006 collection estimates are - \$2.588 billion if the President's proposed legislative initiatives are enacted and \$2.164 if they are not adopted. If the legislative initiatives are not adopted by Congress, then these collections will not materialize.

The methodology used was specific to VA users; it was based on service volume and mix at the encounter level and computed the dollar value of potential and expected collections from collectable patients. Prescription drug co-payment is produced by the VHA enrollee health care demand model. The revenue estimate for the enrollment fee is based on the number of enrollees who are expected to pay the fee.

Summary of Fund Activity				
(dollars in thousands)				
Description	2005 Current Estimate	2006 Estimate	Increase/ Decrease	Comments
Medical Care Collection Fund				
Pharmacy Co-payments.....	\$722,370	\$773,000	\$50,630	The methodology used was specific to VA users; it was based on service volume and mix at the encounter level and computed the dollar value of potential and expected collections from collectable patients.
Third Party Insurance Collections.....	\$1,018,380	\$1,175,625	\$157,245	
First Party Other Co-Payments.....	\$131,450	\$136,052	\$4,602	
Eliminate First-Party Offset.....	\$0	\$30,260	\$30,260	
Long Term Care Co-Payments.....	\$6,600	\$500	(\$6,100)	
Enhanced Use Revenue.....	\$28,625	\$625	(\$28,000)	Funds will be used for West Side Tower construction occurring in 2005.
Compensated Work Therapy Collections.....	\$41,440	\$43,764	\$2,324	Historical trends
Parking Fees.....	\$3,500	\$3,500	\$0	Historical trends
Compensation & Pension Living Expenses..	\$655	\$678	\$23	Historical trends
Subtotal.....	\$1,953,020	\$2,164,004	\$210,984	
Proposed Legislation, User Fees:				
Increase Pharmacy Co-Payments for P7/8s....	\$0	\$176,278	\$176,278	Prescription drug co-payment is produced by the VHA Enrollee Health Care Demand Model.
Assess \$250 enrollment fee.....	\$0	\$247,718	\$247,718	Revenue estimate for the enrollment fee is based on the number of enrollees who are expected to pay the fee.
Subtotal, Prop. Legisl., User Fees.....	\$0	\$423,996	\$423,996	
Total Collections.....	\$1,953,020	\$2,588,000	\$634,980	

Question 5: Please provide an estimate of the cost savings anticipated from the two electronic data projects that are underway to improve VA's billing and collections (referenced in Secretary Nicholson's statement, page 6) and when those cost savings are expected to begin.

Response: The electronic insurance identification and verification project (e-IIV) enables VA medical centers to send electronic queries to insurance companies regarding a veteran's insurance benefits. Faster queries and responses are expected to save on costs by reducing the time required—today, by telephone—to obtain insurance coverage information. To date cost savings have not been realized for this initiative because of challenges. VA is collaborating with industry groups to encourage adapting standard processes to benefit payers as well as providers in regard to obtaining insurance information.

The electronic outpatient pharmacy claims processing initiative (e-Pharmacy claims) will speed the process of claims adjudication by providing responses from payers in real-time. Initial version has been released to make possible testing of real-time claim submission and required preparation steps at VA sites; the next iteration (containing expanded functionality) is scheduled for release December 30, 2005. Simultaneously, VA is working with payers to support their transition from accepting paper to receiving electronic pharmacy claims.

E-Pharmacy claims software is primarily driven by HIPAA requirements and payer requirements to move to standard electronic claims. Revenue impact is limited by VA's flat rate for all prescriptions (even those for 90-day supplies) and by the relatively small number (approximately 10 percent) of veterans who have pharmacy benefits to cover non-service-connected medications. However, this software (coupled with another initiative that requires service or non-service connection designation on all pharmacy orders) is expected to enable VA to increase its pharmacy collections by approximately \$7 million, dependent of course upon the adjudication practices of payers.

While both of these initiatives streamline VA's business processes, cost savings are depend not only on VA electronic infrastructure but also on the readiness of external payers. The October 2003 deadline for compliance with HIPAA electronic transaction and code sets (ETCS) regulations has come and gone. Yet the health care industry is still far from prepared to fully comply with most HIPAA standard transactions. Due to the complexities involved, the Department of Health and Human Services has permitted a contingency period to enable covered entities to transition to full compliance and at the same time not disrupt cash flows or health care operations. Therefore, the benefits of moving to these industry standard processes have not been fully realized, and may not be for some time to come.

Question 6: What VA-DOD resources and/or services are in the proposed planning of the new medical facility in Las Vegas?

Response: VA's construction of a comprehensive medical center in Las Vegas will certainly change the nature of the VA/DoD joint venture. VA/DoD sharing will continue to be robust after completion of the medical center. Clinical specialty services not available at the Mike O'Callaghan Federal Hospital (MOFH), currently being purchased in the community at retail prices will be available to Air Force beneficiaries at the VA medical center at discounted rates. Specific services will include cardiac catheterization, vascular surgery, orthopedic surgery, nephrology, bariatric surgery, wound care, hyperbaric therapy, pathology and laboratory services, radiologic services, and gastroenterology services.

- VA will use Air Force gynecology specialty services for VA beneficiaries at the MOFH.
- As programs are finalized for the new medical center, a sharing agreement will be negotiated with the Air Force and serve as their justification for recruitment of specialty physicians that will compliment VA staff and meet mutual clinical needs.
- The close proximity of the MOFH and the VA medical center will provide synergy to reinforce cooperation and optimal use of both facilities for the collective beneficiaries.
- Emergent and acute care will be provided at the VA medical center while the Air Force will focus primarily on ambulatory services. The exception to this will be obstetrics.
- Local VA and Air Force officials have a very close collaborative historical partnership. Planning is underway to consolidate, where feasible, joint training and education. VA and Air Force are looking for ways to combine purchasing and contracting efforts to maximize the economy of scale and reduce the unit costs for both organizations. Both parties are committed to meeting the healthcare needs of all beneficiaries with their collective resources.

Question 7: The Medical Facilities Program Resource Data (Volume 2 of 4; page 4-22), shows a loss of \$21 million in sharing and other reimbursements under the 2006 estimate. Please explain the drop in estimated reimbursements from 2005 to 2006.

Response: The decrease of \$21 million is attributable to (1) anticipated proceeds of \$22 million from the transfer of real property to be deposited in the VA capital asset fund in 2005 and (2) a projected increase of \$1 million in reimbursements. See chart below.

Description	Dollars in Thousands			
	2004 Actual	2005 Current Estimate	2006 Estimate	Increase/ Decrease
Reimbursement	\$11,163	\$13,000	\$14,000	+\$1,000
VA capital asset fund	\$0	\$22,000	\$0	-\$22,000
Total	\$11,163	\$35,000	\$14,000	-\$21,000

Question 8: The Disabled American Veterans has referred to a critical mass, which assumes a patient population of "x", in order to sustain a viable health care system and provide a full continuum of quality care and specialty care to disabled veterans in the future. Does the Department's actuarial projection model include a reference point or the estimation of critical mass in this context?

Response: The VHA health care demand actuarial model provides the data needed to assess the concept of critical mass. For any policy scenario under consideration, such as open enrollment, limited enrollment, cost-sharing, etc.; the demand model can project future veteran enrollment and health care service use for over 50 health care services, including mental health services and special VA services such as prosthetics.

In assessing critical mass, health care service use is the critical indicator, rather than patients, for several reasons. First, the morbidity of veterans who use VA health care services varies; therefore, some patients use more health care services than others. In addition, veterans do not come to VA for all of their health care needs, and the amount and type of care a veteran receives from VA versus other health care providers varies significantly. Thus, a change in the absolute number of patients does not adequately reflect the resultant change that is expected in use of particular health care services.

Also, different policies will impact the use of health care services differently. For example, charging Priority 7 and 8 enrollees an annual enrollment fee is not projected to impact use of inpatient, mental health, or special VA services, therefore, the policy will not affect critical mass for these services. However, this policy is expected to cause a moderate reduction in outpatient services and prescription drug use. Since the demand model quantifies these reductions, VA can use this data to assess any impact on critical mass for these services and the size and type of health care infrastructure needed to support the reduced service levels.

Question 9: The budget notes that the Education Service is working with the National Association of State Approving Agencies to develop outcome measures related to VA education programs. When does the Department expect to complete that development of measures?

Response: Education service is continuing to partner with the National Association of State Approving Agencies (NASAA) to develop outcome measures designed to measure the degree to which the Montgomery GI Bill has assisted service members and veterans in achieving their educational goals. VA is currently developing the methodology to collect required data and determine targets. NASAA hopes to be able to distribute a survey late in 2005. VA will provide more information in the fiscal year (FY) 2007 budget submission and plans to have some initial survey results in the FY 2008 submission.

Question 10: The Vocational Rehabilitation and Employment Performance Measures shown in the budget have several measures listed as TBD. These TBD measures largely address the veteran's success following completion of the VR&E program. How does the Department propose to manage outcomes if there are no performance measures that follow the veteran in the workplace.

Response: The vocational rehabilitation and employment (VR&E) program has four performance measures listed as to be determined (TBD) in the FY 2006 budget submission:

- Percent of participants employed first quarter after program exit;
- Percent of participants still employed three quarters after program exit;
- Percent change in earnings from pre-application to post-program employment; and
- Average cost of placing participant in employment.

The VR&E program has not yet set strategic goals and fiscal year targets for these measures because they are being developed as "common measures" to be used by multiple federal, state, and local employment and training programs. The source proposed for collection of data to support these measures is self-reported information, which the Interagency Working Group on Common Performance Measures has determined is not an acceptable source. VR&E Service is not able to set any goals for the common measures until valid statistical data can be collected.

A VR&E counselor determines that a veteran is rehabilitated in an appropriate job by following the veteran for 60 days to ensure that the employment is suitable and stable. The current VR&E program outcome measure, rehabilitation rate, is calculated by taking the number of veterans rehabilitated and dividing it by the total number of veterans exiting the program.

Question 11: In the FY06 budget VA estimates a 3 percent increase in VBA's workload. What are the major factors contributing to the increase? How will continued military operations impact VBA's workload in coming years?

Response: The three percent increase in projected workload is based on the average increase in claims received from FY 2001 to FY 2004. VA received 674,219 claims in FY 2001 and 771,115 in FY 2004 amounting to a cumulative 14.3 percent increase and an average of 3.5 percent over this 4-year period. The current state of hostilities was considered in developing our estimate.

The major factors considered in the projected workload are:

1) An increase in the number of claims received at Benefits Delivery at Discharge (BDD) sites. Over the last 4 years, VA has seen a steady rise in the number of original claims from returning service members and veterans. VA has also experienced a significant rise in the number of veterans claiming eight or more disabilities.

2) An increase in the number of claims for increased benefits as a result of the following:

- The addition of cardiovascular disease and residuals of stroke to the presumptive list of disabilities for former prisoners of war;
- A general counsel opinion clarifying that limitations of motion may be rated under multiple diagnostic codes, affecting claims related to orthopedic conditions;
- An estimated 10,000 reserve component soldiers, sailors, marines, and airmen currently serving on active duty, necessitating actions to terminate and subsequently resume disability benefits; and
- An increase in service-connected death claims due to the aging of veterans currently on the compensation rolls.

Question 12: VBA's pending claims workload has declined over the past few years. As of Feb. 5, there were 341,985 rating cases pending. Is this considered an acceptable ratings inventory? In light of the Veterans Claims Assistance Act, what does VBA consider to be a reasonable "work-in-progress" inventory?

Response: The number of claims received and the length of time it takes to process those claims dictate the level of claims inventory. VBA has made good progress in reducing both the average processing time and claims inventory. However, more progress is needed to achieve the service delivery goals. Taking into consideration the experience with notification "wait periods" implemented as a result of the Veterans Claims Assistance Act and the workload projections, VA has adjusted the performance target for "average processing time" to 145 days for FYs 2005 and 2006, and the strategic goal to 125 days. VA's inventory targets have been adjusted to 290,000 in FY 2005 and 283,000 in FY 2006. VA continues to target a working inventory of 250,000 rating claims for the longer term.

Question 13: What is the Department doing to ensure Operation Iraqi Freedom/Operation Enduring Freedom service members are identified and provided the benefits they deserve. What changes in processing has the Department made to expedite the claims for the returning service members?

Response: VA has a number of outreach initiatives to ensure that returning service members are aware of the benefits available to them. A summary of those activities follows:

Transition Assistance Program (TAP) and Other Military Services Briefings.

From October 2002 through March 2005, VBA military services coordinators conducted transition briefings and related personal interviews in the U.S. as reflected in the chart below. These briefings include pre- and post-deployment briefings for Reserve and National Guard members.

OVERALL BRIEFINGS

<i>Fiscal Year</i>	<i>Briefings</i>	<i>No. Attendees</i>	<i>No. Interviews</i>
2003	5,368	197,082	97,352
2004	7,210	261,391	115,576
2005*	2,263	79,105	34,106

*through March 2005

In addition to military services briefings in the US, VBA representatives conduct briefings overseas under arrangement with DoD. VBA provides two tours each year with six to seven VBA representatives providing this service for each tour. Each is home-based at a major military site and provides services at the site and surrounding areas. The countries serviced are England, Germany, Japan, and Italy. Korea is serviced by staff from the BDN in Yong San. A representative from the St. Petersburg Regional Office provides that service for Guantanamo Bay. VA was recently requested by DoD to add Bahrain to the overseas schedule beginning with the May 2005 tour. The following chart reflects statistics regarding overseas briefings:

OVERSEAS BRIEFINGS

<i>Fiscal Year</i>	<i>Briefings</i>	<i>No. Attendees</i>	<i>No. Interviews</i>
2003	472	12,943	5,050
2004	624	15,183	6,544
2005*	232	5,684	2,141

*through March 2005

Briefings for Reserve/Guard Members. Outreach to Reserve/Guard members is part of the overall VBA outreach program. In peacetime, this outreach is generally accomplished on an "on call" or "as requested" basis. With the activation and deployment of large numbers of Reserve/Guard members following the September 11, 2001, Attack on America, and the onset of OEF/OIF, VBA outreach to this group has been greatly expanded. National and local contacts have been made with Reserve/Guard officials to schedule pre- and post-mobilization briefings for their members. Returning Reserve/Guard members can also elect to attend the formal 3-day transitional assistance program (TAP) workshops. The following data on Reserve/Guard briefings is a subset of the overall briefings data provided in the first chart:

RESERVE/GUARD BRIEFINGS		
<i>Fiscal Year</i>	<i>Briefings</i>	<i>No. Attendees</i>
2003	821	46,675
2004	1,399	88,366
2005*	974	68,351

*through March 2005

Briefings Aboard Ships. VA provided TAP briefings aboard the USS Constellation, the USS Enterprise, and the USS George Washington on their return from the Persian Gulf to the U.S. VBA will continue to support requests from the Department of the Navy for TAP workshops aboard ships.

Seamless Transition - Military Treatment Facilities (MTFs).

In 2003, VA began placing veterans service representatives at key military treatment facilities (MTFs) where severely wounded service members from OEF/OIF are frequently sent. Representatives of the VBA BDD office in Germany work closely with the staff at the Landstuhl Army Medical Center to assist returning injured service members who are patients at that facility and family members temporarily residing at the Fischer House.

Since March 2003, a VBA OEF/OIF coordinator is assigned for each MTF. Full time staff is assigned to the Walter Reed Army Medical Center in Washington, D.C., and the Bethesda Naval Medical Center in Maryland. Similar teams work with patients and family members at three other MTFs serving as key medical centers for seriously wounded returning troops: Eisenhower, Brooke, and Madigan Army Medical Centers. Itinerant service is conducted at all other major military treatment facilities. As of January 2005, over 4,500 hospitalized returning service members were assisted through this program at Walter Reed, Bethesda, Eisenhower, Brooke, and Madigan. Since March 2003, each claim from a seriously disabled OEF/OIF veteran is case managed for seamless and expeditious processing.

Web Page. As part of the Seamless Transition effort, VBA created a new web page for OEF/OIF, directly accessible from the VA homepage. Information specific to Reserve/Guard members who were activated is included, as well as links to other federal benefits of interest to returning service members. The web page has been accessed over 340,000 times since its activation in December 2003.

Benefits Delivery at Discharge (BDD). VA's BDD program operates in concert with the military services outreach program. Under BDD, service members can apply for disability compensation within 180 days of discharge. The required physical examinations are conducted and service medical records are reviewed prior to discharge. The goal is to adjudicate claims within 30 days following discharge. Upon receipt of the claimant's DD Form 214 (Report of Release from Active Military Service), benefits are immediately authorized so that the recently separated veteran can receive his/her first disability check the month following the month of discharge or shortly thereafter. Currently, 141 military installations worldwide participate in this program, including two sites in Germany and three in Korea. Approximately 26,000 BDD claims were finalized in FY 2003; 40,000 in FY 2004; and 12,000 in FY 2005 to date.

Recently-Separated Veterans

Veterans Assistance at Discharge System (VADS). All separating and retiring service members (including Reserve/Guard members) receive a "Welcome Home Package" that includes a letter from the Secretary, a copy of VA Pamphlet 21-00-1, *A Summary of VA Benefits*, and VA Form 21-0501, *Veterans Benefits Timetable*, through VADS. Similar information is again mailed with a 6-month follow-up letter.

Secretary's Outreach Letter to Returning Service Members. Outreach letters from the Secretary have been sent to approximately 240,000 returning service members who have separated/retired from active duty. Enclosed with the letters are copies of VA Pamphlet 21-00-1, *A Summary of VA Benefits*, and IB 10-164, *A Summary of VA Benefits for National Guard and Reserve Personnel*.

News Releases. Last year, VA produced a 30-second video entitled "Our Turn to Serve" which was distributed to domestic viewing markets near or at major military transition and separation bases. It was placed as a streaming video file on the VA Internet Web site and marketed electronically to other domestic TV station programmers in markets with large military populations. It is now about to run on the armed forces radio and television service outlets serving military personnel based overseas. A new VA outreach video program, "The American Veteran," is airing on the Pentagon channel, which reaches military audiences at DoD installations, communities and sites in this country and around the world. It is a half-hour video magazine featuring stories and information of interest to

military personnel and veterans that focuses on their benefits and how they can access and use them. This is a continuing series of monthly programs that will be marketed domestically to cable systems, public broadcasting stations, and community access cable.

Priority Claims Processing. VBA provides case managed priority claims processing for all seriously injured returning service members.

VA's goal is to award benefits within 30 days from the date of receipt of the claim for compensation (if the service member has been discharged from the military).

VA provides expedited claims processing for active component personnel through the BDD program and specialized outreach to returning Guard and Reserve personnel.

Questions for the Record
Honorable Michael Bilirakis
House Committee on Veterans Affairs
February 16, 2005

Hearing on the VA Budget for FY06

Question 1: On page two of the Department of Veterans Affairs testimony, it stated that there is a need to ease service member's transition from active duty to civilian life.

DoD and VA have stated that there are 139 military installations with BDD programs. GAO reported in November of 2004, that when they evaluated 8 of these installations it found that only 4 of the installations had included a single separation exam in its BDD program.

How many BDD sites have implemented all components of the program and what is the timetable for full implementation at all sites?

Response: In November 2004, VA and DoD signed a memorandum of agreement for a cooperative separation process/examination. This agreement includes a single separation physical examination that meets VA's disability compensation and the military's separation examination protocols.

VA subsequently issued implementation instructions to all Veterans Benefit Administration (VBA) and Veterans Health Administration (VHA) field facilities requiring that a new memorandum of understanding (MOU) be signed with DoD at every Benefit Delivery at Discharge (BDD) site (with the exception of the seven Coast Guard sites not under DoD's jurisdiction). As of April 2005, there are 50 signed MOUs in place that incorporate the single separation process/examination, and over 80 other MOUs are near completion. The sites previously identified by General Accountability Office as not in full compliance with the single separation process/examination have either already submitted a new MOU or they are in the process of finalizing one. VA anticipates full implementation the third quarter of FY 2005.

Question 2: How is DoD cooperating with VA in this effort?

Response: DoD has been a cooperative, active partner in this process.

Question 3: Given that the Veterans' Disability Benefits Commission was charged with issuing its report not later than 15 months after a majority of the members had been appointed, please provide a timeline on when the Commission might schedule its first meeting?

Response: VA has worked with Chairman James Terry Scott, LTG USA (Ret), to establish the Commission. VA has identified key staff, acquired office space, and purchased computer equipment for the Commission and its staff. Chairman Scott held public meetings on May 9 and June 9, 2005.

Question 4: How is the VA Medical and Prosthetics Research program preparing to deal with the high-tech prosthetics needs of service members separating from service in Iraq and Afghanistan?

Response: The VA medical and prosthetics research program continues to support a broad prosthetics research portfolio to meet the needs of the newest veterans separating from service in Iraq and Afghanistan. VA is increasing its support of multidisciplinary prosthetics research approaches and examination of enabling technologies that aim to ease the physical and psychological pain of veterans. In addition to evaluating existing practices, VA is expanding upon its longstanding support for advances in surgical approaches to primary amputation to include operative revision and limb lengthening procedures that can potentially aid in fitting prostheses and enhance function beyond what is now possible. VA is also aggressively examining other techniques such as Osseo integration, a procedure that replaces missing limbs with titanium rods inserted directly into residual bone. The overarching goal of these activities is to maximize the function and well-being of veteran amputees.

Examples of VA prosthetics research efforts include:

**Partnerships with the Department of Defense (DoD) and
Walter Reed Army Medical Center (WRAMC)**

Investigating Immediate Challenges Faced by Returning Service Personnel: This is a joint project involving VA researchers and clinicians, clinician scientists, and soldiers at WRAMC to (1) compare prosthetic designs, (2) define standards of function, (3) evaluate psychological issues faced by returning service personnel, (4) determine psychosocial issues that challenge successful reintegration, and (5) initiate longitudinal studies to be carried out as the injured soldiers transition into the VHA.

VA Centers of Excellence

VA Centers of Excellence assemble multidisciplinary teams of investigators with complementary backgrounds, skills and training to pursue long-term research agendas. The centers are expected to provide cutting edge solutions to issues of particular concern to the healthcare of veterans. Each center develops an integrated thematic research core as a unifying focus of research activities.

(1) Center of Excellence for Limb Loss Prevention and Prosthetic Engineering: Located in Seattle, WA, the mission of the center is to conduct basic and clinical

research that affects the quality of life and functional status of veteran amputees and veterans who are at risk for amputation. Investigators are performing head-to-head prosthetic design trials, using tele-rehabilitation to prevent primary amputation and secondary complications in amputation, and are improving current prosthetic designs.

(2) Center of Excellence in Tissue Engineering to Rebuild, Regenerate, and Restore Function after Limb Loss: The Providence VA Medical Center (VAMC), in collaboration with Brown University and the Massachusetts Institute of Technology, has established a Center of Excellence to advance amputee healthcare and the concept of a "biohybrid" limb. The goal is for VA clinician scientists to create "biohybrid" limbs that will use regenerated tissue, lengthened bone, internal and external titanium implants and sensors that allow amputees to use brain signals and residual limb musculature to move their prostheses.

(3) The Advanced Platform Technology Center of Excellence: The Advanced Platform Technology Center in Cleveland, OH will bridge the gap between state-of-the-art technologies being developed for general use and their application and expansion to the unique needs of veterans with all forms of physical disabilities. The center's focus is on sensory and implanted control of prosthetic limbs, accelerated wound healing, and biological sensors for the detection of health and function.

VA Quality Enhancement Research Initiative (QUERI)

The mission of QUERI is to enhance the quality and outcomes of VA healthcare by systematically implementing clinical research findings and evidence-based recommendations into routine clinical practice.

Accelerating Implementation of Best Practices for Traumatic Amputation and Polytrauma: The Polytrauma QUERI will coordinate a multidisciplinary team of national experts in rehabilitation, health services, and implementation science in disseminating and applying results emerging from multiple venues, including VA amputation and prosthetics research, to accelerate the diffusion of best practices.

Additional Efforts in Prosthetics Research

(1) Increasing Options for Upper Limb Amputees: VA researchers in Chicago, IL are working to develop and evaluate a first of its kind, four degree-of-freedom prosthetic hand and controller for use by persons with amputations at or near the wrist to allow coordinated control of individual digits on an artificial hand.

(2) Osseo integration to Alleviate Chronic Problems Associated with Current Prosthetic Designs: VA funds Osseo integration studies at the San Diego, Salt Lake City and Providence VA medical centers that examine bacterial resistant

tissue seals, mechanical designs that alleviate stress-mismatch of titanium inserts, use of antibiotics, and cellular immune responses to infection.

(3) Freeform Fabrication of Transtibial Prosthetic Sockets: A VA project in San Antonio, TX is continuing the development of an alternative method of socket fabrication using solid freeform fabrication based on selective laser sintering technology that allows the direct manufacture of a prosthetic socket without the intermediate molds and laminating process required with conventional techniques.

(4) Increasing Proficiency of Prosthetic Use for Maximum Function and Long-term Health: A VA evidence-based amputee rehabilitation project that involves an intervention protocol consisting of an exercise program to improve strength, balance and endurance that is targeted to older veterans with amputations. If successful, future directions include expansion of services for all amputees and across other VA sites. The VA investigator leading this study organized a weeklong clinic for advanced prosthetics and training for amputee soldiers at WRAMC. Every soldier was fit with a new athletic or running prosthesis and then trained to run. Each soldier had the opportunity to work with four Paralympics Gold medalists from Athens, Greece. This was an educational venue for VA clinical personnel, military therapists, and others. VA clinics that support the active pre-morbid levels of activity will help soldiers transition to veteran status and open the door to advanced studies in prosthetic design, use, and long-term functional recovery for all amputees.

(5) Enhancing Peripheral Nerve Regeneration through Modified Polymer Conduit: VA is funding a pilot study in Detroit, MI to determine the efficacy of a chitosan-based nerve guide conduit. Animal model tests will involve repair of severed nerves to examine sensory and motor recovery. The potential application to veteran amputee healthcare is significant. Peripheral nerve injuries often occur within the residual limb of the amputee resulting in phantom limb pain. If left untreated, the amputee will not have the ability to capitalize upon peripheral nerve-driven prostheses under development at the Providence VAMC Center of Excellence in Tissue Engineering to Rebuild, Regenerate, and Restore Function after Limb Loss.

Proposals Under Review

On February 28 and March 1, 2005, VA reviewed 19 research proposals in its Prosthetics and Orthotics panel. Proposal topics included: designing prostheses that promote ambulation; increasing function in upper-limb prosthetic design; developing actively powered lower-limb prostheses; developing computer aids for prosthetic prescriptions; reducing stress in prosthetic socket design; and Osseo integration. Awards will be announced in May 2005.

Question 5: The Subcommittee has noted that there has been a lack of funding for administrative support for research. During several hearings, it became

apparent that the VA has not been aggressive in efforts for funding administrative support and the Institutional Review Boards (IRB) that ultimately provides the necessary protections for veterans enrolled in research.

How much funding has been dedicated to funding research support and IRBs in your 2006 budget proposal?

Response: In response to the recognition of the growing responsibilities of Institutional Review Boards (IRBs), the VA Office of Research and Development has established new programs and funding sources related to human subject protections that bolster their traditional sources of support.

Funding for administrative support for research and IRBs comes from several sources. The following is an overview of funding for research support and IRBs proposed for FY 2006:

Medical and Prosthetics Research Business Line

- Veterans Equitable Resource Allocation (VERA): \$393 million of VERA funds are allocated based on support of research in FY 2006. These funds will be distributed to VA medical centers based on the amount of direct research funding they receive from VA. According to VHA Handbook 1200, VERA funds should be used to provide indirect support for research, including but not limited to, scientific and administrative support for research and development committees and subcommittees. It also states that the medical center director must provide for administrative support of the IRB, Institutional Animal Care and Use Committee and research safety committees as well as VA staff time in support of IRB activity.
- Funds from the Medical and Prosthetics Research (M&PR) appropriation are also used to supplement VERA funds in support of research. In FY 2006, these funds will be approximately \$27.5 million, accounting for 7 percent of the M&PR appropriation. The funds will be distributed to VA medical centers based on the average amount of direct research funding they have received from VA over the last 3 years.
- In addition, approximately \$5 million of the M&PR appropriation will be dedicated to salary costs for IRB-related activities.
- To support activities of local IRBs, the Office of Research and Development created the Program on Research Integrity Development & Education (PRIDE) in March 2003 to oversee education, training, and policy development related to human subject protection in VA research. PRIDE works closely with VA facilities to prepare them for accreditation with the National Committee on Quality Assurance (NCQA). In 2000,

when VA contracted with NCQA to accredit its medical centers, it became the nation's first research institution to require independent and external accreditation for all sites that conduct human studies. All VA sites with active human research protection programs are expected to be NCQA accredited by the end of calendar year - 2006.

Non-VA Funds

- Facility Human Protection Program (FHPP): The program, established in 2003, generates funds through a 10 percent tax on direct costs of human studies funded by private industry. FHPP funds are administered by VA non-profits and academic affiliates and may be used for human subjects' research compliance activities, excluding IRB activities. In FY 2006, it is expected that approximately \$5 million could be made available to VA medical centers in reimbursements and "in-kind" support that may be used for compliance related activities.
- IRB Fees: Study administration entities (VA non-profits and academic affiliates) typically charge private sector study sponsors a direct fee for IRB-related costs. Typical fees range from \$1,500 to \$2,500 for an initial IRB review. These fees are either passed through to the institution incurring the IRB-related costs (academic affiliate or VA) or they may be used to pay costs directly. For public sector funding, indirect costs of research, including IRB fees, are collected by the study administration entity (VA non-profits and academic affiliates) from the public sector funding source (e.g., National Institutes of Health).

Question 6(a): The Subcommittee received a letter dated February 11, 2005 from Deputy Secretary Gordon Mansfield regarding a further delay of the VBA's deployment of its automated claims processing program, VETSNET. The program has been going on for 12 years at a cost of \$400 to \$500 million.

Response: From 1986 through 1995, VBA spent \$318 million to upgrade our information technology infrastructure (sometimes referred to as "modernization").

Specific examples of what VBA funded as part of this effort include:

- Installation of VBA's email system;
- A modern network of personal computers (including intelligent workstations for all VBA employees);
- Wide area networks with increased capacity to move data needed by different sites; and
- Software applications for Loan Guaranty, Vocational Rehabilitation and Employment, and Education.

Between 1996 and 2004, VBA spent \$46.2 million for VETSNET. In FY 2005, \$10.7 million is budgeted for VETSNET. From 1996 through 2005, VETSNET funding includes the costs for applications development, testing, deployment, operation and maintenance, and program management support.

Question 6(b): VA testified in March 2004 that VETSNET would be fully deployable by December 2005. Now there is another year's delay. Please provide the Subcommittee with the cost associated with this delay.

Response: The total cost of full VETSNET deployment will not change as a result of the schedule change.

Question 6(c): Would you please explain what problems caused this delay and why the new date of December 2006 that is now being given for full deployment is a reliable one?

Response: The primary reason for this delay is the need for VBA to minimize adverse impact to the claims processing workload. VBA goal is to deploy in a manner that:

- Has the least adverse impact on veterans and regional office claims processing;
- Builds on lessons learned from prior deployments of other projects (MAP-D, RBA 2000; coreFLS); and
- Accommodates existing resource levels and considers impact assessments and the needs of VBA business users.

The following factors were considered in setting the new date for full deployment:

- Pace of absorption of new VETSNET functionality by the business users;
- Need for rigorous independent verification and validation testing;
- Intensive business and user pre-deployment testing of all application components;
- Availability of VBA resources;
- Use of a methodical approach to ensure accurate and timely payments;
- Scheduled deployment of application functionality to minimize workload and production impact;
- Input of regional office and business staff;
- Alignment of application deployment with extensive user training; and
- Application of lessons learned from successfully deployed projects such as RBA2000 and MAP-D, as well as from unsuccessful projects such as HRlink\$, coreFLS and FBI's Trilogy.

VBA is closely managing the implementation of VETSNET through weekly meetings of the VETSNET Executive Board with the Under Secretary for Benefits, as well as through the Monthly Performance Review with the Deputy

Secretary. The VA CIO and the Under Secretary for Benefits have agreed with and are committed to this deployment schedule.

Question 7: Congress mandated that the VA integrate the Department's financial and management information systems. What has happened to the VA's failed demonstration project (coreFLS) in Bay Pines, with a cost (of) \$342 million?

Response: On July 13, 2004, the Secretary announced his decision to move the core financial and logistics system (coreFLS) project from the Office of the Assistant Secretary for Management to the Office of the Assistant Secretary for Information and Technology and establish the VA coreFLS board of directors as the mechanism for key decision making on go forward issues. The membership includes the most senior leaders in VA, including the chief information officer, chief financial officer, and under secretaries. Subsequent to forming the board, on July 26, 2004, the Secretary announced the decision to phase out the coreFLS pilot program designed to test the integrated financial and logistics management system at the Bay Pines Medical Center and two focus sites, the National Cemetery Administration and Veterans Benefits Administration.

Currently, tasks are underway to evaluate VA's financial and logistics business processes. On December 15, 2004, PricewaterhouseCoopers was awarded a competitive procurement, firm fixed price contract to:

1. Analyze the "as is" business processes;
2. Identify specific actions to be taken to resolve the FFMIA material weakness, "Lack of an Integrated Financial Management System";
3. Develop "to be" finance and logistics business processes that will form the basis for how VA intends to do finances in the future. The "to be" or future business processes will have to reconcile back to the "as is" condition to ensure that current state has a target, future state; and
4. Identify potential solutions including commercial and government off-the-shelf software and the financial management line of business.

This effort was completed in early June. Since that time, the coreFLS board of directors have been briefed and are currently deliberating on the degree of standardization of business processes across the VA. Integrated systems issues and acceptable products will be addressed after the board comes to a decision.

Question 8: The VA testified that it expects to collect \$2.6 billion in 2006. This is \$635 million over the 2005 estimate. The VA's testimony further stated that it would adopt industry-based performance and operational metrics, develop technological enhancements and use industry proven best practices. Please explain how the Department intends to develop and implement this in one year, and please provide the implementation timetable and milestone dates.

Response: The FY 2006 collection figure of \$2.6 billion referenced in the hearing represents a \$635 million increase over our estimate for FY 2005. However, two thirds of this increase is contingent upon the passage of two legislative proposals (the \$250 enrollment fee and the increase in pharmacy co-payments from \$7 to \$15 for veterans in Priority Groups 7 & 8).

Over the past several years, VA has initiated a comprehensive assessment of ongoing revenue activities in an effort to develop "industry best practices", adopt industry-based performance and operational metrics. VHA is also implementing technological initiatives designed to ensure that VA is properly compensated for the services provided to those veterans with private health insurance coverage.

Many of these initiatives have already been major factors in VA's collections improvement from \$ 771 million in FY 2001 to \$1.7 billion in FY 2004. VA met FY 2004 performance targets for key operational metrics including: total collections, gross day's revenue outstanding, accounts receivable greater than ninety days, and days to bill. These metrics are recognized as industry standard measurements of revenue cycle performance success.

VHA has automated a number of critical revenue processes, which have improved collections. These project initiatives and their status are listed in the table below:

Project Name	Description	Results
Electronic Claims Submission	A system that makes possible submission of claims electronically to third party insurers.	Complies with standards mandated by HIPAA (Health Insurance Portability and Accountability Act); streamlines claims submission. As of March 2005, more than 15 million electronic claims have been generated. Monthly average of electronic claims for last six months of calendar 2004 was 20 percent higher than for previous six months.
Electronic Payments	A system that makes possible electronic receipt of remittance advices and payments.	Complies with standards mandated by HIPAA; makes possible electronic receipt of insurance remittance advices and electronic funds transfer. In 2004, e-Payments were awarded the Kevin O'Brian Automated Clearing House Quality Award for innovative and aggressive implementation of improved business processes, by the National Automated Clearinghouse Association (NACHA), which represents over 12,000 financial institutions. Results for VA include: <ul style="list-style-type: none"> – 64% efficiency gain in administrative processing <ul style="list-style-type: none"> ▪ Receipt processing more efficient ▪ Remittance matching, verification, posting automated where applicable – \$2.9 million estimated cost avoidance in out years
First Party Call Center	A centralized call center for veterans with questions concerning co-payment bills.	Improved customer service for veterans and significant reduction in calls directly to medical center billing offices. The call center is presently on line at eight Veterans Integrated Service Networks (VISN).
Electronic Insurance Identification and Verification (e-IIV)	A system to electronically identify and verify insurance plans.	Since the national rollout of e-IIV in September 2003, VA has received 102,442 payer responses reporting eligibility that assisted in the collection of approximately \$7.5 million.
First Party Lockbox	A system to automatically apply payments from veterans to their outstanding co-payment charges.	Automation of payments has simplified the process for veterans, significantly reduced processing time, and freed facility staff to concentrate on follow-up of insurance claims. On average, the lockbox processes \$50

Pre-Registration	An automated utility to support the update of demographic and insurance data prior to patient visit or admission.	million per month. Pre-registration is an industry proven practice for improved revenue performance VA has identified thousands of new insurance policies as a result. VA mandated pre-registration in 1998 and has developed a monitor for performance. Completed projects have consistently resulted in improved reimbursement rates for VA Medical Centers on average of 30 to 50 percent. Additionally, VA received a settlement of \$5.4 million from a single insurer for prior underpayments. VA presently is working on over 50 payer projects.
Payer Compliance	A program to assist VA in validating that payments received by third party insurers for a particular service are the same as that received by other non-governmental providers in the same geographic area for the same service.	

Question 9: Please provide an explanation of the two electronic initiatives VA intends to implement. Please include development and implementation costs and milestone dates.

Response:

Electronic Insurance Identification and Verification project (e-IIV)

The e-IIV project, developed and implemented to comply with transaction standards legislated by the HIPAA, enables VA medical centers to send electronic queries to insurance companies regarding a veteran's insurance benefits.

Milestone dates:

- e-IIV software released—October 2003.
- Enhancement released—February 2005.
- Currently underway: further enhancements analysis
 1. Enhanced payer set-up/connection capabilities
 2. Refinements based on industry variability in adopting HIPAA standards
- Implementation support to end-users—ongoing.

While initiatives streamline VA's business processes, cost savings are depending not only on VA electronic infrastructure but also on the readiness of external payers. The October 2003 deadline for compliance with HIPAA electronic transaction and code sets (ETCS) regulations has come and gone. Yet the health care industry is still far from prepared to fully comply with most HIPAA standard transactions. Due to the complexities involved, the Department of Health and Human Services has permitted a contingency period to enable covered entities to transition to full compliance and at the same time not disrupt cash flows or health care operations. Therefore, the benefits of moving to these

industry standard processes have not been fully realized, and may not be for some time to come.

e-Pharmacy Claims

The primary objective of this initiative is to provide the VA medical centers with the software required to submit electronic outpatient pharmacy claims using the HIPAA-compliant NCPDP (National Council for Prescription Drug Programs) format. Additionally, this initiative will provide VA medical centers the ability for third-party claims adjudication in real time.

Milestone dates:

- October 2004: Initial software foundation delivered. Enabled test pilot at 8 VA medical centers to send electronic pharmacy claims, as well as enabled the rest of the VA medical centers to accomplish preliminary implementation steps in preparation for sending electronic pharmacy claims. For example, the collection and data entry of national bank identification numbers (BINs) and processor control numbers (PCNs) from pharmacy benefit managers and health plans nationwide
 - October 2004 – March 2005 Software testing and business-process refinement
 - March 2005 - Adoption of test results into final requirements
 - April 2005 - Final design review
 - July 2005 - Unit testing of final code
 - September 2005 - Functional integration testing and quality assurance review
 - November 2005 - Regression and final beta testing
 - December 2005 - Final quality review and software release

As with e-IIV, cost savings are dependent not only on VA electronic infrastructure, but also on the readiness of external payers.

Question 10: Please elaborate on the system-wide review of the rating program and what the time frame is to review, re-engineer, and implement changes to provide network wide standards.

Response: In response to a December 2004 congressional request, the Secretary requested that the Office of Inspector General (OIG) conduct a special review to evaluate variances in VA disability compensation payments to veterans residing in different states. The OIG is currently reviewing demographic and benefit rating factors, claims processing attributes, and other VA disability characteristics that may contribute to payment variances by state. The OIG has completed much of its analysis and is beginning to prepare the draft report for management comment. This review remains a high priority for the OIG, and is being accomplished as quickly as possible.

Question 11: Please provide the Subcommittee with the number of recommendations made in the April 2004 Vocational Rehabilitation and Employment Task Force report that have been implemented. What is the timeframe and what are the milestone dates to accomplish the remainder of the recommendations?

Response: The vocation rehabilitation and education task force report included 109 recommendations. As of March 2005, VBA has implemented 46 of these recommendations. VBA plans to implement 16 more within the next 6 months, 17 more within 12 months, and 18 more beyond 12 months. Three of the recommendations are ongoing and a projected completion date is not yet determined. Nine of the recommendations are not appropriate for implementation at this time.

**Questions for the Record
Honorable Cliff Stearns
Committee on Veterans' Affairs
February 16, 2005**

Hearing on VA Budget for FY06

Question 1: Under Burial Administration, Program and Financing 36-0129-0-1-700, 02.02 Construction, Major Projects, could you delineate how the \$41,000,000 you have recommended in FY06 will be spent? Is this specifically for land acquisition for the six new cemeteries authorized under P.L. 108-109, or are there other projects for which this funding is intended?

Response: A total of \$41 million is included in the President's fiscal year (FY) 2006 budget request to acquire land for six new national cemeteries. This funding is specifically designated for land acquisition costs for the new cemeteries authorized under Public Law 108-109. No portion of this funding is earmarked for any specific cemetery site. The \$41 million represents what VA may expect to pay to acquire six properties based on past experience; previous costs have ranged from \$4 million to \$11 million per property, depending on site characteristics. In addition, independent appraisals are obtained to ensure the VA pays fair market value.

Question 2: Recognizing that we are in the environmental assessment phase now, in general, could you please provide a current timeline for these six new cemeteries? An overview and timeline would be helpful.

Response: National Cemetery Administration (NCA) anticipates opening all six new cemeteries by the end of FY 2009. The development of new national cemeteries can extend over a period of five to seven years, depending upon a variety of factors including environmental compliance and land acquisition issues, site characteristics such as terrain, and the availability of funding to support each phase of development.

VA is currently conducting environmental assessments at selected sites for each new cemetery. These assessments should be completed this year and will provide VA with information as to the suitability of individual sites for cemetery development. After completion of the environmental assessments, NCA will begin the process to acquire the preferred sites. The FY 2006 budget includes \$41 million for land acquisition costs for the six new cemeteries authorized by Public Law 108-109.

The next phase involves the preparation of site master plans, design development, and preparation of construction documents. This phase is followed by the award of construction contracts. NCA is planning to open "fast track" gravesite sections in these new cemeteries to expedite burial operations rather than waiting for the entire cemetery to be completed. NCA anticipates opening the "fast track" burial sections for all six new cemeteries by the end of FY 2009.

Questions for the Record
Honorable Jeff Miller
House Committee on Veterans Affairs
Fiscal Year 2006 Budget

Hearing on VA Budget for FY06

Question 1: As the Department knows, the Logistics Management Institute in 2002 identified more than 900 infrastructure deficiencies at both open and closed cemeteries – at a cost of \$279 million – yet the budget request to this end is just \$14 million.

Please briefly explain the Department's plan to address the restoration and repair projects, as well as the progress made to date.

Response: The National Cemetery Administration (NCA) is using a multi-faceted strategy to address cemetery maintenance and repair needs. The Veterans Millennium Health Care and Benefits Act Report to Congress (Volume 2, National Shrine Commitment) provides a comprehensive assessment of the condition of VA's national cemeteries. The report identified the need for 928 repair projects at an estimated cost of \$280 million to ensure a dignified and respectful setting appropriate for each national cemetery. NCA is using the information and data provided in the report to plan and accomplish the repairs needed at each cemetery. Since the report was issued in August 2002, NCA has completed work on 89 projects, and initiated work on additional projects, with an estimated cost of \$77 million.

The report includes an extensive database of condition assessment information. This data is used in the planning process to assist in prioritizing repair projects over a multi-year period. NCA evaluates the problem categories and the severity of problems within each category. Data from NCA's annual survey of satisfaction with national cemeteries is also used to factor in the viewpoint of veterans and their families when determining project priorities.

NCA has also developed new performance metrics that will be used to improve the appearance of its national cemeteries. Baseline data were collected in 2004 for three new performance measures designed to assess the condition of individual gravesites, including the cleanliness and proper alignment of headstones and markers. With this baseline data, NCA has identified the gap between current performance and the strategic goal for each measure.

Approximately one-third of the discretionary budget for burial programs is used for the maintenance of national cemeteries as national shrines. This includes mowing and trimming, routine maintenance as well as repair projects to improve cemetery appearance. The FY 2006 budget requests \$101 million for national

cemetery maintenance, including \$20 million for gravesite renovation and infrastructure repairs.

Repairs to address long-standing deferred maintenance needs are addressed in a variety of ways. Gravesite renovation projects to raise, realign, and clean headstones and markers; and to repair sunken graves will continue to be a high priority in allocating operational resources. Infrastructure improvements to buildings, roads, irrigation systems, and historic structures are addressed with capital expenditures through the major and minor construction programs. In addition, cemetery staff will be used to complete some repairs.

NCA has also established an Organizational Assessment and Improvement Program to ensure regular and consistent assessment of performance against established standards. Each national cemetery will be evaluated through site visits conducted on a cyclical basis. In addition, NCA will develop and evaluate new innovations and equipment to make the most effective use of resources in meeting cemetery maintenance needs.

Question 2: The disability compensation budget supports an additional 113 FTE. When the VA considers retirements, turnovers, and the amount of time it takes to train new hires, will there be sufficient staffing to address the workload?

Response: Maintaining appropriate staffing levels at VA's regional offices is critical to continued improvements in the delivery of benefits and services to veterans and their families. VA has pursued a regular program of recruiting, hiring, and training new employees over the last several years, including hiring 300 veteran service representatives (VSRs) in the fourth quarter of fiscal year (FY) 2004, and approximately 120 additional VSRs so far in FY 2005.

All newly hired VSRs participate in centralized training, provided at one of several locations. This allows newly hired employees to receive standard, consistent training, while also minimizing the number of senior staff who need to be removed from production to assist in providing training at any point in time. This ongoing effort helps to ensure we maintain an adequate number of staff who are trained and qualified to provide the level of service veterans expect and deserve.

Question 3: What measures are being developed to address the backlog of claims?

Response: The Veterans Benefit Administration (VBA) has employed several measures to address our claims inventory. For the past several years, VBA has implemented an aggressive strategy to balance the inventory of pending claims across stations. Cases are sent from stations with high inventories to other stations with the capacity to take on additional rating work. This strategy allows the organization to address the local and national inventory by moving claims to where resources to decide them exist.

In addition to moving the work to where resources are available, VBA has hired and trained more than 300 individuals for critical claims processing positions in the last two fiscal years. Thus far in FY 2005, we have hired an additional 120 VSRs who are now receiving centralized training, and who will help to offset the employees lost through retirement and attrition.

Technology is also a critical factor in achieving operational efficiencies. Applications such as RBA 2000 continue to provide more efficient means for making, capturing, and communicating rating decisions. To support ongoing analysis and performance improvements, a cycle time inventory management system was created. Cycle time reports provide detailed information for regional office management to analyze processing at various steps and make adjustments as needed to improve efficiency and performance.

We continually review our work processes, staffing levels, and regulatory requirements to search for opportunities for improvement, all in an effort to become more efficient and effective in our delivery of benefits to veterans.

Question 4: Included in the Summary volume of the budget is an assumption that the disposition time at the Board of Veterans' Appeals will increase from 170 days at the end of 2004 to 600 days by the end of 2008. This is unacceptable. What will be done to turn this trend around?

Response: In addition to incentives for employees, the Board of Veterans Appeals (BVA) is implementing initiatives to reduce avoidable remands. BVA is training judges and counsel to write more concise, but complete decisions. BVA's judges and attorneys typically deliver results that exceed targets. The targets are developed from potential workload data. We are confident that our initiatives to reduce avoidable remands and VA's efforts to resolve Veterans Claims Assistance Act of 2000 deficiencies will reduce appeals and improve projected disposition times. BVA anticipates improvement on the projections as we achieve success through our initiatives.

Question 5: Could the VA please provide the Committee with the current remand rate, as well as efforts undertaken at the Board of Veterans' Appeals to address their backlog and lower the amount of time it takes to make a decision?

Response: BVA's remand rate for FY 2004 was 56.8 percent. For FY 2005 (as of March 14, 2005) the annual remand rate stands at 44.43 percent but it is trending lower due to remand reduction initiatives. The remand rate stands at 39.26 percent for the period February 1, 2005, through March 14, 2005, and the trend continues to improve.

BVA has initiated measures to reduce avoidable remands. BVA conducted training for all attorneys and judges to decrease avoidable remands. BVA and VBA together developed a tracking system to identify the causes for remands.

When identified, the most persistent reasons for remands are addressed through training, or revised procedures.

A decrease in remands results in fewer pending appeals before VA. This should reduce the backlog and reduce the amount of time it takes for a claimant to receive a decision.

Question 6: What action is the Department taking to reach out to other veteran populations and advise them of their potential benefits' eligibility?

Response: In addition to the outreach programs for active duty personnel and reserve/guard members, the following programs are in place in response to the legislative requirements in Title 38 USC, Title 10 USC, and Executive Orders:

Recently Separated Veterans

All separating and retiring service members (including Reserve/Guard members) receive a "Welcome Home Package" that includes *A Summary of VA Benefits* and other useful information, through our Veterans Assistance at Discharge System. Similar information is mailed with a follow-up letter after six months.

Vietnam Veterans Exposed to Agent Orange

The *Agent Orange Review* newsletter keeps interested Vietnam veterans updated on new medical studies, changes in benefits, and other related information.

Former Prisoners of War (POW)

During FY 2004, another coordinated, nationwide public affairs and outreach campaign was employed to reach former POWs and their families. A news article was released and published in newspapers nationwide. Regional offices are now in the midst of another outreach project resulting from the recently added heart and stroke related presumptive conditions for former POWs.

Casualty Assistance – In-Service Deaths

VBA representatives visit surviving family members, including reserve/guard members, who die while on active duty. The representatives assist family members in applying for benefits. The goal is to process all in-service death claims within 48 hours of receipt of all required documents.

Other Eligible Dependents

VBA sends a *VA Benefits for Survivors* pamphlet to the next of kin of recently deceased veterans. A *VA Benefits in Brief* flyer is also included with acknowledgement letters that VBA sends to claimants for dependency and indemnity compensation, death pension, Chapter 35 education, and insurance.

Homeless Veterans

Twenty regional offices retain at least one full time homeless veterans outreach coordinator. Part-time coordinators are assigned at all other regional offices. Regional offices participate in community sponsored stand downs for homeless veterans.

Women Veterans

A women veterans coordinator is available at each regional office to assist women veterans who need specialized service. VBA representatives work closely with the center for women veterans, the VHA women veterans health program, and the Secretary's Advisory Committee on Women Veterans to improve outreach and service to women veterans.

Native American Veterans

VBA outreach coordinators participate in various events to reach Native American veterans such as by sponsoring benefits briefings on reservations and with local Native American groups. VBA and VHA cooperate in a training program for tribal veterans representatives.

Elderly Veterans

VBA outreach coordinators participate in various scheduled events where elderly veterans and surviving spouses may gather such as senior citizen centers, nursing homes, senior day care centers, etc. Relationships have been established with local area agencies on the aging, social security administration offices, and other agencies and organizations that deal with older Americans.

Project 112/SHAD (Project Shipboard Hazard & Defense)

VBA has mailed 4,328 outreach letters to these veterans. Selected fact sheets are enclosed with the letters depending on the tests the veteran participated in. Efforts continue to obtain names, social security numbers, and current addresses for veterans to whom we have not yet sent outreach letters.

Mustard Agents and Lewisite (Mustard Gas)

VBA is conducting a special outreach effort to veterans exposed to mustard agents or Lewisite, primarily in chemical testing programs during World War II. VA previously conducted an outreach campaign to this veteran population in 1993 using public service announcements. This new effort will be more specific, and include direct mailings to veterans identified by the Department of Defense (DoD) as having been exposed to mustard agents or Lewisite, as well as their survivors. The letter covers VA medical and financial benefits, data about the effects of exposure to chemical warfare agents, and telephone numbers to call VA or DoD for more information. VBA has released letters to those for whom we have been able to identify an address. VBA continues to seek addresses for additional veterans and survivors.

**Questions for the Record
Honorable John Boozman
Committee on Veterans' Affairs
February 16, 2005**

Hearing on VA Budget for FY06

Question 1: The President's budget includes \$5.8 million for a clinic in Fayetteville, AR. Please describe the goals of the project, services the clinic will provide, and milestones.

Response: This project requires \$5.8 million in fiscal year (FY) 2006 budget authority for phase 1, design of the clinical addition, with an estimated total acquisition cost of approximately \$56.163 million.

This project includes the construction of a clinic of approximately 160,000 square feet that will help address the needs of the growing veteran population. It will provide a full continuum of primary care services, as well as enhanced specialty care and supporting ancillary services. Examples of ancillary services to be included are pharmacy, physical therapy, and improved access to laboratory services. The clinic will also help ensure that veterans will have access according to VA's requirement for access to specialty care of 60 minutes drive time for urban and 90 minutes drive time for rural areas.

Additional specialty and ancillary services will maximize this medical center's ability to provide care to facilitate the veterans' physical, mental, and social functioning, as well as improve the timely, accurate completion of compensation and pension exams. With the increase in specialty services, the veteran requiring care will be able to obtain at this facility a variety of specialty and ancillary services that must now be obtained outside the facility. This will improve the ability to obtain these services timely, with one trip to the facility.

VA will realize annual cost savings through a reduction of lease expenses for current off-site space.

Milestone Schedule for the project

The project is in its very early stages; thus milestones are preliminary at this time and dependent, in some cases, on availability of funding.

Complete design development - February 2006

Award construction contract - TBD*

Complete construction - TBD*

*TBD - These dates depend on when appropriations are provided for Phase 2 of this project.

Question 2: The Budget lasts targets of 27 days to process initial claims for education benefits and 13 days for supplemental claims. It is probably fair to say that peak claims processing times are just prior to the beginning of each semester and the subsequent monthly recertification of attendance. Why can't checks be cut as soon as the veteran and/or school officials certify or recertify via the internet?

Response: Peak claims processing times generally include September through November and January through March. For enrollment certifications submitted electronically by school officials, about 15 percent can be processed automatically within one day. Limitations of VA's current systems and individual circumstances for claimants prevent automatic processing of a higher percentage. For those processed automatically, notice is sent to the Treasury Department, which can issue a direct deposit payment within 2 to 3 days; mailing a check takes several days longer to reach the beneficiary.

For beneficiaries who certify their attendance by Internet, processing again takes place within 1 day and direct deposit payments are issued within 2 to 3 days; checks take several days longer through the mail.

We encourage and promote the use of the Internet by schools and students to expedite processing.

Question 3: How much does VR&E spend on contract services and how do you measure the results as compared to veterans served by VR&E staff?

Response: The vocation rehabilitation and education (VR&E) program continues to authorize the use of contract services through the national acquisition strategy program to support VA staff in providing services needed by veterans participating in the VR&E program. The information and table below identifies contract expenditures by the type of service for FY 2004.

Chapter 31 Counseling/Evaluation Assessment activities for individuals being evaluated to establish their entitlement to the Chapter 31 program.

Chapter 31 Rehabilitation Services Vocational rehabilitation case management contractor/fee basis services provided to Chapter 31 participants during a program of rehabilitation services or during a period of program interruption.

Chapter 31 Employment Service Services provided to Chapter 31 participants during a program of employment services.

Fiscal Year	Counseling/ Evaluation	Rehabilitation	Employment	TOTAL
2004	\$4,090,574	\$2,533,814	\$441,862	\$7,066,250

VR&E contractors are accountable and measured for the quality of work performed. Work performed by contractors must be reviewed and approved by a VA employee prior to certification of invoices for payment. VR&E offices are required to maintain information on the contract as well as records on their performance. The contracts are all performance-based contracts.

Additionally, quality reviews at the regional office and headquarters level are conducted throughout the year. Randomly selected cases are reviewed for quality, with no differentiation made between cases handled by a VR&E staff member and those handled by a contractor.

Question 4: The Budget indicates \$2.75 million for training education and voc rehab staff. Please describe how the courseware was developed, by whom and how is it presented to the staff?

Response: The actual budget total for training and performance support system (TPSS) is \$2.275 million, of which \$2.15 million is allocated to Education Service and \$125,000 to VR&E Service.

For FY 2006, Education service requested \$2.15 million for development of TPSS. TPSS is a computer based application that will be integrated into the training curriculum that currently consists of lectures and hands-on training.

The courseware for TPSS training has not been fully developed. Training modules are needed for the purpose of training education employees in the following positions: veterans claims examiners (VCE), education liaison representatives (ELR), education compliance survey specialists (ECSS) and the image management system (TIMS) clerks. To date, six modules have been developed for the VCE position by the Computer Sciences Corporation (CSC) in conjunction with VBA's technical training and evaluation staff. The \$2.15 million requested is for completion of the remaining modules for the ELR, ECSS and TIMS clerk positions.

The VR&E allocation will be used to develop standards of practice for providing services through VR&E and to develop an organizational needs assessment to identify gaps between current and desired performance within the VR&E program. Once training is identified as the appropriate solution, analysis will be conducted to determine how the service is currently using training to increase the level of performance.

Question 5: In the Department's testimony, it indicates VA is to include \$4.4 million to establish self-service job resource labs in regional offices. Isn't this investment in on-line technologies a duplication of services already funded and available to veterans through Department of Labor one-stop centers and the services provide by the Disabled Veterans Outreach Program and Local Veterans Employment Representative? Would the VA agree that there should be absolutely no daylight between VA's Voc Rehab program and Labor's VETS programs, and if so, what are VA's plans to improve cooperation and coordination with the Veterans Employment and Training Service?

Response: The job labs and the online employment technologies are specific resources necessary to support the five-track employment model – the cornerstone of the new employment-driven service delivery system recommended by the VA VR&E task force in their 2004 report to the Secretary. The task force urged VR&E to “retool its comprehensive vocational evaluation, educational, and employment services to the contemporary, real-time employment needs of individual veterans.”

The job labs and online employment technologies are part of a pilot test at four regional offices (Montgomery, St. Louis, Detroit, and Seattle). Conducting the pilot allows VR&E to fully integrate measure, modify, and deliver a tested product prior to a national deployment. It is not VR&E's intent to duplicate services, but rather develop new effective tools and strengthen partnerships with the Department of Labor (DOL) so that VR&E is able to consistently offer strong and comprehensive employment services nationwide.

VR&E must work as seamlessly and as efficiently as possible with DOL and other partners to deliver state-of-the-art employment services. VR&E staff partner with disabled veterans outreach program (DVOP) and local veterans employment representative (LVER) staff to provide effective employment services to veterans with disabilities. VA counselors and employment specialists in 57 regional offices and over 100 out based locations are in contact with DVOPs/LVERs on a daily basis to assist veterans in obtaining information on local labor markets, reemployment rights, interviewing skills, job search strategies, and job leads or referrals. In some locations, a DVOP representative is co-located in the VR&E division of the regional office.

VR&E's new orientation video, the job labs, online technologies, and the employment coordinator position are all components of a new service delivery system that emphasizes the primary goal of returning disabled veterans to suitable employment. The five-track employment model and the new job labs significantly enhance VR&E's ability to execute a plan of services in those areas where DVOPs or LVERs are not co-located or available to assist during the initial vocational evaluation; in researching local labor market information; and in development of a rehabilitation or employment plan. If a veteran arrives at a VA

regional office and wishes to explore career options, it is VR&E's responsibility to have job labs with online technologies available to assist in making a timely and informed choice about employment goals.

DVOPs and LVERs stationed or co-located with VR&E staff can be more efficiently and effectively integrated into the delivery of employment services if they are able to access the same full range of job lab resources and online technologies available to VA staff. Under the five-track employment model, DOL is a vital employment services partner.

VR&E will continue to provide training and updates on recruitment of persons with disabilities for all partner agencies or organizations. VR&E has established regularly scheduled meetings with DOL's veterans and employment training service (VETS) to explore mutual areas of training and more effective linkages for service delivery. National VR&E/VETS meetings are supplemented by regional office contact with their local VETS counterparts

**Questions for the Record
Honorable Ginny Brown-Waite
Committee on Veterans Affairs
February 16, 2005**

Hearing on VA FY 2006 Budget

Question 1: Won't the proposed enrollment fee for Category 7 and 8 veterans act as an impediment to the use of the VA system?

Response: Some Priority 7 and 8 enrollees will choose not to pay the enrollment fee, and therefore, will not use the VA health care system. These enrollees are expected to make this decision based, in large part, on whether or not they have other health care coverage options. It is likely that some lower priority veterans will decide to receive more health care services from non-VA sources (e.g., using their personal insurance coverage).

Question 2: Is discouraging use of VA health care by Category 7 and 8 veterans the intended goal of enrollment fee or is it a side effect?

Response: The proposal will refocus resources on VA's core medical care mission – serving veterans with military disabilities, low incomes, and special needs (*such as spinal cord injuries*) – by charging new fees to all other veterans that better align with the private sector (*health care deductibles and co-pays*). VA proposed the enrollment fee for Priority 7 and 8 enrollees in order to refocus the VA health care system on those veterans who need VA most. With the implementation of the enrollment fee, VA expects that 78 percent of the total number of veteran patients using VA's health care system in 2006 will be veterans with service-connected medical conditions, special needs, and low incomes, up from 73 percent in 2004.

**Questions for the Record
Honorable Michael R. Turner
Committee on Veterans Affairs
February 16, 2005**

Hearing on VA FY 2006 Budget

Question 1: The president's budget request for fiscal year 2006 proposes decreases of \$123,734,000 in obligations and 3,299 in full time employees in regard to nursing home eligibility, as well as decreases of \$84,827,000 in appropriation and 1,065 in full time employees, also in regard to nursing home eligibility. In light of the increasing number of veterans expected to use nursing home facilities, how does the department plan to meet this increased caseload while simultaneously proposing to reduce available resources for nursing home care?

Response: VA underestimated the number of long-term beds by nearly 1,600 beds, and used an average cost per bed that was too low. This resulted in a shortfall of \$446 million in the 2006 budget that will be funded with a 2006 budget amendment.

The fiscal year (FY) 2006 budget provides all long-term care needed for veterans who have a service-connected disability. It also provides for patients requiring short-term care subsequent to a hospital stay, those needing hospice or respite care, and those with special needs such as ventilator dependence or spinal cord injury. Where institutional care is required but not provided by VA, veterans will use other Federal and State programs including Medicare and Medicaid, private insurance and personal resources.

The FY 2006 budget also proposes an 18 percent increase in the average daily census of veterans receiving care in the spectrum of non-institutional home and community-based services provided and paid for by VA. This is in keeping with VA's long-standing policy of seeking to provide care in the least restrictive setting that is compatible with a veteran's medical condition and personal circumstances and maintaining veterans in the home and community with their family, friends, and spiritual community whenever possible, reserving nursing home care for situations in which the veteran can no longer safely reside at home.

Questions for the Record
Honorable Lane Evans
Committee on Veterans' Affairs
February 16, 2005

Hearing on Department of Veterans Affairs
Fiscal Year 2006 Budget

Question 1: Various proposals have been suggested to provide increased amounts of life insurance to service members serving in combat areas. These proposals include recommendations for the government to assume the cost of increased premiums for combat veterans. Please explain the implications of such proposals for the functioning, stability and premium charges of the SGLI Program.

Response: Recently enacted legislation increases the maximum amount of service members' group life insurance (SGLI) coverage from the current \$250,000 up to \$400,000, coupled with an increase in the DoD death gratuity from \$12,420 to \$100,000. Recently enacted legislation also provides for automatic, free coverage for \$150,000 of the \$400,000 maximum to service members serving in combat areas.

The increase in the maximum amount of SGLI coverage to \$400,000 requires an increase in the basic SGLI premium rate about one year after the date of enactment. VA estimates that the premium rate will need to be raised from \$.065 to \$.075 per month per \$1,000, which would represent a 15 percent increase. For the full \$400,000 of coverage, the monthly premium would therefore increase from \$26 to \$30. The primary reasons why the SGLI premium rate will need to be increased are:

- The larger coverage amount will result in higher claim payments that will not be covered by the additional premiums received at the current \$.065 rate. Currently, the interest earnings of the program and any extra hazard reimbursements due from DoD, fund most of the difference between the premiums received and the claims paid. If coverage is increased to \$400,000, the gap between the premiums and the claim payments will grow, while the interest earnings of the program would change very little. We would have to address the resulting deficit by an increase in the SGLI monthly premium rate. VA estimates the increase would rise from \$.065 per \$1000 to \$.075 per \$1000 within a year of increased coverage. If there were no such increase in coverage, we estimate the same increase in premiums would not be required until the year 2010.
- The cost of veterans' group life insurance (VGLI) conversions will increase. Service members have the right to convert their SGLI coverage to VGLI without providing evidence of good health when they leave or retire from service. Because this is a valuable benefit, a substantial number of disabled veterans exercise this conversion privilege. VGLI premium rates

are designed only to cover the claims cost of "standard" mortality, although VGLI has a disproportionate share of disabled individuals. Therefore, when these conversions take place, a one-time charge is assessed to the SGLI program to cover the future anticipated mortality costs that will not be covered by the VGLI premiums charged. An increase in SGLI coverage would result in higher amounts of coverage being converted to VGLI and therefore higher conversion costs.

- The target level for the SGLI contract contingency reserve (CCR) will need to be increased from its current target level of \$375 million. The CCR represents the surplus of the SGLI program and its purpose is to cover the risk of a peacetime catastrophic incident (natural disaster). If coverage is increased to \$400,000, we estimate that the CCR target level will need to be increased to about \$500 million to maintain the financial integrity of the program. While the CCR now stands at about \$650 million, we anticipate that the higher costs described in the two paragraphs above will reduce it to near the new \$500 million target in about one year.

Any retroactive costs to pay such benefits would need to be funded through appropriations since no premiums or extra hazard reimbursements were collected for these retroactive benefits.

Question 2: Although the number of appeals pending has almost doubled in the past four years, there is no indication of funding in the budget to address the increased appeals workload and especially those remanded claims which have been pending for years. What additional number of FTE would be needed to reduce the number of remands pending for more than one year to less than 1,000 by the end of FY 2006?

Response: The Veterans Benefits Administration (VBA) does not require additional staff to reduce the number of remands pending. The high number and average age of pending remands are more closely related to procedures and processing requirements than to a lack of available resources.

VBA remains committed to processing remands in a timely manner, and has devoted an additional 26 staff from the St. Petersburg Regional Office to remand processing in the second quarter of fiscal year (FY) 2005. This is in addition to 10 staff in the Huntington, West Virginia Resource Center and 16 staff in the Cleveland Tiger Team previously devoted to remand processing.

It is not a matter of staffing, but a matter of the legal requirements associated with evidence development under the Veterans Claims Assistance Act of 2000 that delay the quick resolution of remands. In addition, remands are unique in that they almost invariably require VBA to complete a series of sequential development instructions, with response periods of at least 60 days between each step. Frequently, the development required by the Board of Veterans' Appeals directs VBA to repeat prior efforts to assist the veteran obtain medical treatment or other

records that date back many years. The custodians of these records are often very difficult to locate. VA must also initiate or repeat prior exhaustive efforts to obtain any federal records, such as those from the Social Security Administration. These efforts must continue until and unless VA is reasonably certain that the records do not exist or that further pursuit of the records would be futile. Finally, remand orders often require VBA to obtain complex medical opinions from medical specialists that may not be readily available at all VA medical centers or in smaller cities, further delaying processing.

Question 3: I am concerned that the decrease in funding proposed for training in the President's budget will further erode VA's ability to provide correct and timely decisions the first time. How can VA decrease training and improve service?

Response: VBA is not decreasing training; training remains a critical element in improving the professionalism of the workforce and the training budget has been fairly steady over the past several years. Earlier this year, VBA hired approximately 350 new veteran's service representatives (VSRs) for whom VBA is conducting centralized training, requiring an increase in travel funds in the FY 2005 budget. Because VBA does not plan to conduct similar centralized training in FY 2006, the budget reflects a decrease in the amount of money requested for travel. However, field station training and leadership training have not been reduced; in fact, an even greater emphasis is placed on training in FY 2006.

Question 4: It is my understanding that staffing for the home loan program can be cut, based in part on the current low default rates and health of the program. Are you prepared to request additional funding in the event that there is an increase in the number of loans needing assistance to avoid foreclosure in FY 2006?

Response: The Under Secretary for Benefits monitors the status of defaults and foreclosure avoidance activities on an ongoing basis. If a change in the economy should make it necessary, VBA will take appropriate action to ensure that sufficient resources are available to service mortgages for veterans who are in default.

Question 5: Various proposals have been suggested to increase the amount of SGLI insurance retroactive to October 7, 2001. What would be the impact of a retroactive increase to \$300,000 maximum insurance on the SGLI Program? Could such an increase be funded without increasing premiums on servicemembers?

Response: The amount of retroactive costs would depend on whether such benefits are paid for all insured service members who died since October 7, 2001 or for just those insured who died as a result of Operation Enduring Freedom Operation Iraqi Freedom (OEF/OIF). Presumably, the additional \$50,000 payment would be made only for those who carried the maximum amount of SGLI coverage. If payments are made only on OEF/OIF deaths, the estimated retroactive cost would be \$95 million based on the Office of Management and Budget estimate of about 1,900 deaths through FY 2005. If payments are made

for all program deaths from October 7, 2001 through FY 2005, the estimated cost would rise to \$413 million.

As stated in the response to question 1, all retroactive costs to pay such benefits would require appropriated funds since no premiums or extra hazard reimbursements were collected for these retroactive benefits. There would be no legal or actuarial basis for taking this money from the SGLI program. Furthermore, doing so could jeopardize the financial health of the program and result in an earlier than anticipated premium increase for service members.

Beyond the retroactive payments, an increase in the SGLI maximum insurance amount from \$250,000 to \$300,000 will eventually lead to an increase in the SGLI premium rate. Our best estimate of the timeframe for this increase would be sometime in 2008. We project that the premium rate will need to be increased from \$.065 to \$.075 per month per \$1,000. For the full \$300,000 of coverage, the monthly premium would therefore increase from \$19.50 to \$22.50. The primary reasons why the SGLI premium increase will be required are as follows:

- The larger coverage amount will result in higher claim payments that will not be covered by the additional premiums received at the current \$.065 premium rate. Currently, the interest earnings of the program and any extra hazard reimbursements due from DoD, fund most of the difference between the premiums received and the claims paid. If coverage is increased to \$300,000, the gap between the premiums and the claim payments will grow, while the interest earnings of the program would change very little. The resulting deficit would have to be addressed at some future date by an increase in the SGLI premium rate.
- The cost of VGLI conversions will increase. Service members have the right to convert their SGLI coverage to VGLI without providing evidence of good health when they leave or retire from service. Because this is a valuable benefit, a substantial number of disabled veterans exercise this conversion privilege. VGLI premium rates are designed only to cover the claims cost of "standard" mortality, although VGLI has a disproportionate share of disabled individuals. Therefore, when these conversions take place, a one-time charge is assessed to the SGLI program to cover the future anticipated mortality costs that will not be covered by the VGLI premiums charged. An increase in SGLI coverage would result in higher amounts of coverage being converted to VGLI and therefore higher conversion costs.

Question 6: Describe the procedures used to implement and monitor the expedited treatment of remands from the United States Court of Veterans Appeals and the Board of Veterans' Appeals. What are the three most common reasons for delays of more than six months in expediting remands?

Response: In late 2003, VBA established the Appeals Management Center (AMC) to process all remands and to ensure consistency and dedicated attention to the remand workload. Over 8,000 cases were remanded by the Board of Veterans' Appeals (BVA) to VBA when VA decided to terminate BVA's development of cases on appeal and to resume remanding to VBA appealed cases needing further development. The AMC continues to process most remands since that time, although regional offices receive a small number of remands for various procedural reasons. Seventy-four percent of all remands pending at the end of February 2005 are under the jurisdiction of the AMC. The AMC's workforce is specifically trained and skilled in processing these uniquely challenging cases.

To further address the pending remand inventory, VBA added additional resources from three regional offices to remand processing in the second quarter of FY 2005. This is a temporary measure to decrease the remand inventory. Once the inventory is sufficiently reduced, the AMC will be able to maintain a regular operating inventory and to process remands more timely.

There are many reasons why remands take much longer than six months to process, but three common reasons are as follows.

- First, the legal requirements for evidence development under the Veterans Claims Assistance Act of 2000 reflected in remand instructions delay the quick resolution of remands. Frequently, BVA directs VBA to repeat prior efforts to assist the veteran obtain medical treatment or other records that date back many years. The custodians of these records are often very difficult to locate. VA must also initiate or repeat prior exhaustive efforts to obtain any federal records, such as those from the Social Security Administration. These efforts must continue until and unless VA is reasonably certain that the records do not exist or that further pursuit of the records would be futile.
- Second, remands are unique in that they almost invariably require VBA to complete the development steps in a specific sequence, with response periods of at least 60 days between each step.
- Third, remand orders often require VBA to obtain complex medical opinions from medical specialists that may not be readily available at all VA medical centers or in smaller cities, further delaying processing.

Question 7: How are VETSNET applications, including SHARE, which interact with the BDN or Master Record system tested and validated? For FY 2004 and the first quarter of 2005 provide a list of the applications tested, the date testing was begun, any problems identified in the testing which required modification to the BDN or Master Record system and the date the application was validated and certified by the audit division.

Response: For VETSNET applications, including SHARE, that interact with the benefit delivery network (BDN) or master record system, modifications are coded by legacy BDN programmers and tested by BDN analysts each quarter. Testing includes unit level and integration testing. Tested processes are then turned over to the Hines systems implementation division, quality assurance staff, and the user community for validation and certification on a quarterly basis. The list of applications tested and certified in this fashion includes SHARE, search and participant profile, modern award processing – development, rating board automation 2000, award, the financial accounting system, index and split/merge processing (i.e., utilities). The index application identifies whether a record is active in BDN or VETSNET, and the split/merge application allows VBA to operate in both BDN and VETSNET.

For FYs 2004 and 2005, problems identified in testing involved minor coding errors as well as incomplete or incorrect data provided to BDN from SHARE. These coding errors and data problems were corrected prior to modifications being placed into production. Additionally, improved integration testing strategies were implemented for each quarterly cycle.

Question 8: Provide a copy of the integrated project plan for VETSNET, including major VA and contract staff responsible for conversion development, test and implementation coordination of VETSNET and BDN applications.

Response: The comprehensive project management plan for VETSNET is currently being updated to be consistent with the latest schedule and the VA project management methodology. A copy of the current draft is attached.

Question 9: Provide a copy of the risk assessment plan and analysis for VETSNET, including any modifications made since October 1, 2003 and any modifications made as the result of lessons learned from the CoreFLS failure.

Response: The primary risk that VBA is trying to minimize or eliminate is any adverse impact to veterans or interruptions in the work process. Accordingly, the identification of VETSNET risks and the establishment of mitigation plans are conducted on an ongoing basis. The draft comprehensive VETSNET project management plan (which is being updated to be consistent with the latest schedule and with the VA project management methodology) contains the current VETSNET risk assessment plan and analysis (copy of current draft attached). As noted in the draft project management plan, a current risk list is contained in the Office of Management and Budget Exhibit 300 for VETSNET (copy attached).

Lessons learned from coreFLS that VBA has applied to VETSNET include the absolute necessity to minimize any adverse impact to veterans or interruptions in the work process; the importance of establishing internal controls (for example, use of separate VETSNET contractors for development and independent verification and validation); incorporation of the business lines and end users in an organized user acceptance testing program; attention to change management; selection of a small rather than large office for initial live field testing (Lincoln,

Nebraska for VETSNET as compared to Bay Pines for coreFLS); proper training methods (the use of mandatory, live, hands-on training for VETSNET as compared to computer-based training and videos for coreFLS); parallel testing of both new and legacy systems (as compared to the complete "cut over" to the new system for coreFLS); and the continuation of the legacy system until the new system is completely deployed (as compared to turning off the old system for coreFLS).

Question 10: Provide a description of the current criteria for claims paid using VETSNET (e.g., veteran with or without dependents, rating, survivors with or without dependents, apportionment cases, EFT or paper payment) and a timetable for complete conversion of all regional offices and all applications, including the date the BDN is expected to no longer be in use.

Response: Three of the five major applications of VETSNET are already being used in all regional offices as the basis for claims processing for all disability compensation and pension claims (i.e., search and participant profile, which records and updates basic information about veterans and their dependents; modern award processing-development, which develops the claim; and rating board automation 2000, which rates the claim). All five VETSNET applications (including award, which prepares the award, and the financial accounting system, which pays the award) are being used by the Lincoln and Nashville Regional Offices to pay electronic funds transfer disability compensation claims for veterans being added to VA's rolls (including veterans with spouses) who are rated from 10 percent through 100 percent (except for apportionments).

Based on lessons learned from coreFLS as well as from the deployment of modern award processing-development and rating board automation 2000, VBA has developed a systematic approach with an end goal of full deploying VETSNET to all regional offices and conversion of all existing BDN compensation and pension payment records by December 2006. Based on lessons learned from coreFLS, as well as recommendations from the claims processing task force, it is necessary that both systems coexist until the migration from the legacy to the new system has been completely accomplished.

Additionally, to ensure that VBA minimizes or eliminates adverse impact to veterans or interruptions in the work process, VBA has developed an index that enables VBA to continue both systems until VBA has fully deployed VETSNET. As described in the answer to question 7, above, the index identifies whether each record is active in BDN or VETSNET.

Question 11: The Administration has handed VA what is essentially a flat-lined budget. As your testimony notes, Congress has twice considered and rejected legislation to increase veterans' co-payments for pharmaceutical drugs and new enrollment fees. It has also refused to allow VA to abandon its long-term care capacity requirement. If Congress once again rejects these initiatives what sort of hole will this leave in VA's budget?

Response: If Congress rejects the initiatives, VA will experience a \$1.152 billion shortfall in FY 2006. However, the Administration is going to send a 2005 Budget Supplemental shortly, and plans to address any 2006 shortfall with a Budget Amendment.

Policy	2006 Impact (\$M)
\$250 Enrollment Fee	-\$454
\$15 Pharmacy Co-Payment	-\$202
Long-Term Care Policy	-\$496
Total Above Policies	-\$1,152

Question 12: VA officials have repeatedly asserted that veterans prefer to receive long-term care services in the home. Does the Administration, then, view home and community based long-term care services as a one-for-one substitute for nursing home care? If not, what deficiencies do you see in the VA system for veterans—particularly lower priority veterans—as a result of completely eliminating eligibility for nursing home care available through the VA for some?

Response: Home and community-based long-term care services do make it possible for some elderly people who would have required nursing home care in the past to now remain in home and community settings close to family, friends, and their spiritual community. VA seeks to provide care in the least restrictive setting that is compatible with a veteran's medical condition and personal circumstances, reserving nursing home care for situations in which the veteran can no longer be safely maintained at home. VA will provide all needed long-term nursing home care for our highest mission priority, service-connected disabled veterans. VA will also provide care for patients needing short-term care subsequent to a hospital stay, those needing hospice or respite care, and those with special needs such as ventilator dependence or spinal cord injury for who care is not available in the community.

Question 13: Who will be responsible for "lower priority" veterans, including medically indigent veterans, with a need for nursing home care once VA closes its doors to them and stops funding their care in the community and state homes?

Response: Where institutional care is required and not provided by VA, veterans will use other Federal and State programs including Medicare and Medicaid, and other private and public programs.

Question 14: I have to say that of all the Administration's proposals to stop funding per diem payments and place a moratorium on grants to state homes, as far as I am aware, caught all of us flat-footed. In the Senate yesterday VA stated that this would shift about \$300 million for nursing care to the state—I believe that estimate may be conservative because many homes might have to close so financing for others (including veterans' spouses) using state homes could also fall to the States. This accounts for about 60% of the veterans now using state homes. An initial review of the proposal by the National Association of State Veterans Homes suggests that 80 percent or more of the veterans currently

receiving the per diem would be dropped from coverage under the President's budget. Has VA completed an impact analysis of this proposal, including identifying how many state homes might close as a result of adopting this proposal? Has VA discussed this proposal with the National Association of State Veterans Homes or any of the States representatives—the National Governors Association or the National Council of State Legislators, for example? If so, what was their response?

Response: VA has discussed the budget proposal with the National Association of State Veterans Homes and the National Association of State Directors of Veterans Affairs. Their responses were somewhat mixed, but as anticipated generally not favorable. The impact of this proposal is uncertain, as the cost of care in state veterans' homes varies by state and the states employ a variety of funding mechanisms and provide varying amounts of assistance to the homes. VA does not plan to conduct a formal impact analysis.

Question 15: When the National Association of State Veterans Homes provided testimony to this Committee last year, they noted that the State Homes can deliver long-term health care to our nation's veterans at roughly half the cost than the VA. A VA Inspector General's report supports this proposition. Given the economies of providing care through the State Homes, why is the State Home system targeted for substantial cuts at this time?

Response: The state homes do not provide the restorative and rehabilitative care that VA nursing home care units provide, and cannot reasonably compare their costs to VA's costs. The FY 2006 budget provides all needed long-term nursing home care for our highest mission priority, veterans with a service-connected disability. It also provides VA care for patients requiring short-term care subsequent to a hospital stay, those needing hospice or respite care, and those with special needs such as ventilator dependence or spinal cord injury. To assure fairness and consistency, VA proposes similar eligibility criteria across all institutional long-term care venues: VA nursing home care units, contract community nursing homes, and state veterans homes. The per diem for other portions of the state veterans' home program including domiciliary care, hospitals, and adult day healthcare is not reduced by the proposed budget.

Question 16: VA has yet to provide the Committee with any accounting for the \$1.2 billion in management efficiencies it has programmed into its budget and yet it is asking Congress to write off another \$590 million in the fiscal year 2006 budget with little explanation of how these further efficiencies will be found. Please include VA's plan for the hearing record.

Response: The \$1.8 billion in management efficiencies is composed of recurring and anticipated new efficiencies in standardization of pharmaceuticals and supplies; inventory management; productivity; and administrative/clinical consolidations and VA/DoD sharing. The following table provides a breakdown of our projected savings:

Category	FY 2006
Recurring efficiencies from prior year	\$1.199 billion
Standardization of pharmaceuticals & other pharmacy savings	\$340 million
Standardization of other supplies / materials, equipment & inventory management	\$94 million
Productivity	\$50 million
Administrative consolidations, VA/DoD sharing, competitive sourcing, and other	\$106 million
Total	\$1.789 billion

Question 17: VA estimates that it will cut about 2% of its direct care staff—mostly nurses. How does VA plan to effectuate this cut—will it use reduction-in-force (RIFs) or buyouts?

Response: In order to minimize its effect on the VA health care system, the decrease is spread across different areas and does not focus primarily on one group (i.e., nurses). The decrease of 3,712 full time employees (FTE) is comprised of the following:

- An increase of 627 FTE for VA's mental health initiative to deliver equitable access to care and an integrated system of mental health and substance abuse care that is readily available to veterans across the nation.
- A decrease of 4,364 FTE associated with implementing a comprehensive set of legislative and regulatory proposals designed to concentrate health services on VA's highest priority veterans.
- An increase of 25 FTE for the DoD and VA health care sharing incentives fund, a joint incentive program to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels.

- VA believes that the necessary reductions can be accomplished thru normal attrition and re-assignment of affected staff. It does not anticipate the need for reduction in force authority or furloughs to implement the necessary set of legislative and regulatory proposals designed to concentrate health services on VA's highest priority veterans.

Question 18: VA has proposed a \$100 million increase for Mental Health initiatives. What are VA's plans for this increase?

Response: The priorities for using this additional funding are continued expansion of post traumatic stress disorder (PTSD) services and OIF/OEF mental health services; expansion of substance abuse services; expansion of mental health services in community based outpatient clinics; creation of new Mental Health Intensive Case Management Teams (MHICM) teams and services to the seriously mentally ill veteran; new domiciliaries for homeless veterans; and creation of case manager positions for the grant and per diem program.

Question 19: What care and services are veterans of Afghanistan and Iraq seeking? Does this budget request support these services for new veterans? Are there initiatives in the fiscal year 2006 submission that are specifically geared to helping returning troops?

Response: Returning service members from OIF/OEF generally seek the same benefits that all separating/retiring service members seek: compensation for service-connected disability, vocational rehabilitation and employment benefits, education benefits, and loan guaranty benefits.

The FY 2006 budget submission supports the following on-going programs that assist our returning troops:

- Seamless Transition Program for service members who are medically separated or retired. Through this program, VBA works with active duty personnel at the start of the military medical evaluation board and/or physical evaluation board process to provide claims assistance and vocational rehabilitation and employment evaluations, and discuss health care eligibility. A VA seamless transition office has been established to monitor and coordinate these efforts.
- Benefits Delivery at Discharge (BDD) Program, which allows service members to begin the VA disability application process 180 days prior to separation. To expedite claims procedures, VA and DoD have agreed upon a single examination process, using VA's protocols, if an examination is also required by the military prior to separation. A memorandum of agreement to establish single examination procedures was signed between VA and DoD on November 17, 2004. The BDD program is currently offered at 141 military installations. In FY 2004, the BDD program received 39,885 claims from transitioning service members. The disability determination

component of the program is currently being consolidated into two rating activities at the VA Regional Offices in Salt Lake City, UT, and Winston-Salem, NC.

- Transition Assistance Program briefings for returning service members. These joint briefings with the Department of Labor educate service members on the veterans' benefits available to them and include pre- and post-deployment briefings for reserve and National Guard members. VBA conducted 7,210 such briefings in FY 2004 for over 261,000 service members and their families and has conducted 2,263 such briefings as of the end of January 2005. VBA also conducts briefings overseas under arrangement with DoD.

OIF/OEF veterans have sought VA health care for a wide-variety of physical and psychological problems. The most common health problems have been musculoskeletal ailments (principally joint and back disorders); diseases of the digestive system (with teeth and gum problems predominating); and mental disorders (predominantly adjustment reactions). The medical issues VA has seen to date are those VA would expect to see in young, active, military populations, and no particular health problem stands out among these veterans at present. VA will continue to monitor the health status of recent OIF/OEF veterans to ensure that VA aligns its health care programs to meet their needs. VA is confident that our FY 2005 budget and the Presidents' FY 2006 budget request contain sufficient funding to allow VA to continue to provide for all the health care needs of OIF/OEF veterans. Following is a brief description of VA initiatives that have been developed in response to the service needs of veterans from OIF/OEF. Many of these are brand new programs that were developed to meet these needs. All of them represent "lessons learned" from VA's experiences responding to the health care and other benefits needs of veterans returning from the 1991 Gulf War, and from the Vietnam War before that.

Immediate Health Care Needs for Combat Veterans: In response to immediate health concerns for OIF/OEF veterans, on March 26 and 27, 2003, VA developed a program called "Caring for the War Wounded," which was broadcast over the VA Knowledge Network satellite broadcast system. This program provided timely and relevant information about the anticipated health care needs of veterans of the current conflict in Iraq, included VA experts on treatments for traumatic injuries; chemical warfare agent health effects; infectious diseases; radiological health effects; and post-deployment readjustment health concerns, and was converted into a new veterans health initiative health care provider independent study guide, called "Caring for the War Wounded," which is available online at vaww.va.gov/VHI/ and on the Internet at <http://www.appc1.va.gov/vhi/>.

New Clinical Guidelines for Combat Veteran Health Care: In collaboration with DoD, VA developed two Clinical Practice Guidelines on combat veteran health issues, including one general guideline to post-deployment health, and a second dealing with unexplained pain and fatigue. The new clinical guidelines give VA

health care providers the best medical evidence for diagnoses and treatment. VA highly recommends these for the evaluation and care of all returning combat veterans, including veterans from OIF/OEF. The value of the guidelines in providing care to returning veterans is described in a video "The Epic of Gilgamesh: Clinical Practice Guidelines for Post-Deployment Health Evaluation and Management," at www.va.gov/Gilgamesh.

New Specialized Combat Veteran Health Care Program: In 2001, VA established two new War Related Illness and Injury Study Centers (WRIISCs) at Washington, DC, and East Orange, NJ, Medical Centers. Today, the WRIISCs are providing specialized health care for combat veterans from all deployments who experience difficult to diagnose but disabling illnesses. Concerns about unexplained illness are seen after all deployments including OIF/OEF, but VA is building on its understanding of these illnesses. More information is available online at www.va.gov/environagents under the heading "[WRIISC Referral Eligibility Information](#)."

Expanded Education on Combat Health Care for VA Providers: In addition to the programs already described, VA has developed several Veterans Health Initiative Independent Study Guides relevant to veterans returning from Iraq and Afghanistan:

- "A Guide to Gulf War Veterans Health" was originally on health care for combat veterans from the 1991 Gulf War. The product, written for clinicians, veterans and their families, remains very relevant for OIF/OEF combat veterans because many of the hazardous exposures are the same.
- "Endemic Infectious Diseases of Southwest Asia" provides information for health care providers about the infectious disease risks in Southwest Asia, particularly in Afghanistan and Iraq. The emphasis is on diseases not typically seen in North America.
- "Health Effects from Chemical, Biological and Radiological Weapons" was developed to improve recognition of health issues related to chemical, biological and radiological weapons and agents.
- "Military Sexual Trauma" was developed to improve recognitions and treatment of health problems related to military sexual trauma, including sexual assault and harassment.
- "Post-Traumatic Stress Disorder: Implications for Primary Care" is an introduction to post-traumatic stress disorder diagnosis, treatment, referrals, support and education, as well as awareness and understanding of veterans who suffer from this illness.
- "Traumatic Amputation and Prosthetics" includes information about patients who experience traumatic amputation during military service, their rehabilitation, primary and long-term care, prosthetic, clinical and administrative issues.
- "Traumatic Brain Injury" (TBI) presents an overview of TBI issues that primary care practitioners may encounter when providing care to veterans and active duty military personnel.

All are available in print, CD ROM, and on the web at www.va.gov/VHI.

Outreach to Combat Veterans: VA has many new products to offer combat veterans and their families.

- The Secretary sends a letter to every newly separated OIF/OEF veteran, based on veterans' records provided by DoD. The letter thanks the veteran for their service, welcomes them home, and provides basic information about health care and other benefits provided by VA.
- In collaboration with DoD, VA published and distributed 1 million copies of a new short brochure called "A Summary of VA Benefits for National Guard and Reservists Personnel." The new brochure does a tremendous job of summarizing health care and other benefits available to this special population of combat veterans upon their return to civilian life (also available online at www.va.gov/EnvironAgents).
- "Health Care and Assistance for U.S. Veterans of Operation Iraqi Freedom" is a new brochure on basic health issues for that deployment (also at www.va.gov/EnvironAgents).
- "OIF and OEF Review" is a new newsletter mailed to all separated OIF/OEF veterans and their families, on VA health care and assistance programs for these newest veterans (online at www.va.gov/EnvironAgents).
- "VA Health Care and Benefits Information for Veterans" is a new wallet card that succinctly summarizes all VA health and other benefits for veterans, along with contact information, in a single, wallet-sized card for easy reference (also at www.va.gov/EnvironAgents).

Special Depleted Uranium Program: OIF veterans concerned about possible exposure to depleted uranium (DU) can be evaluated using a special DU exposure protocol that VA began after the 1991 Gulf War. This program offers free DU urine screening tests by referral from VA primary care physicians to veterans who have concerns about their possible exposure to this agent.

Combat Veteran Health Status Surveillance: Today VA can monitor the overall health status of combat veterans very efficiently by using VA's electronic inpatient and outpatient medical records. This surveillance summarizes every single visit by a combat veteran including all medical diagnoses. VA has developed a new clinical reminder (part of VA's computerized reminder system) to assist VA primary care clinicians in providing timely and appropriate care to new combat veterans.

Question 20: (VHA-MC-20) VA has proposed a \$100 million increase for prosthetics. What are VA's plans for this increase?

Response: Prosthetic and sensory aids service (PSAS) is an integrated delivery system designed to provide medically prescribed prosthetic and sensory aids, devices, assistive aids, repairs and services to eligible disabled individuals to facilitate the treatment of their medical conditions. This is provided in a seamless action from prescription through procurement, delivery, training, replacement (when necessary), and repair. Prosthetic items include all aids, appliances, parts or accessories which are required to replace, support, or substitute for a deformed, weakened, or missing anatomical portion of the body.

Examples of prescribed prosthetic items and sensory aids are aids for the visually impaired, artificial limbs, terminal devices, stump socks, hearing aids, speech communication aids, home dialysis equipment and supplies, medial equipment and supplies, optical supplies, orthopedic braces and supports, orthopedic footwear and shoe modifications; ocular prostheses, cosmetic restorations, ear inserts; wheelchairs and mobility aids, etc. PSAS processes clothing allowance benefit claims, furnishes automobile adaptive equipment to eligible veterans who have purchased or leased a vehicle, and manages the Home Improvement and Structural Alterations (HISA) Program.

The eligibility criteria for providing prosthetic services have been significantly simplified per the Veterans' Health Care Eligibility Act of 1996, P.L. 104-262. Eligibility categories of veterans to whom VA shall furnish prosthetic services included veterans in need of care for a service-connected disability, veterans who have a service-connected compensable disability; veterans whose discharge or release from active military service was for a compensable disability; veterans eligible pursuant to section 1151 of title 38 U.S.C.; former prisoners of war; and veterans exposed to a toxic substance, radiation, or environmental hazards in the Persian Gulf (limited to certain disabilities). Other categories of veterans to whom VA may furnish care are those non-service-connected veterans whose incomes and net worth are above the "means test" threshold, i.e., Priority 7 veterans including zero percent service-connected veterans who are not in receipt of compensation needing care for non service-connected conditions.

VHA provides new and emerging technology as it becomes available in the marketplace. VHA has a model of care in place that has been serving veterans since 1946. VHA is able to respond to changing technology and support the introduction of new technology. VHA refits, repair, adjust and replace this technology as the veteran progresses through life-changing conditions as he ages. Examples of high tech surgical implants include drug eluding stents, deep brain stimulators, defibrillators and left ventricular assist devices. VA provides this technology through a system of over 500 private contractors who are part of various clinic teams at the medical facility.

VHA has and will continue to be prepared to receive the combat injured and support them with the latest in new artificial limb technology, like the C-Leg. It is important to point out that the VA's policy of providing high technology extends to all the special disabled categories of patients such as spinal cord injured, blind, traumatic brain injury and hearing impaired. Examples of items provided to them are computers for the blind that have speech output, lightweight titanium wheelchairs, power-assist and high-end power wheelchairs, digital hearing aids, and voice activated environmental control units for high-level spinal cord injured.

The reasons for the proposed \$100 million increase for prosthetics are:

In FY 2004 prosthetics obligations totaled \$961 million even though the centralized budget totaled \$935 million. The amount allotted to prosthetic and sensory aids service (PSAS) in FY 2005 was \$947 million - less than what VHA actually spent during the previous year and only a 1 percent increase over the budget allocation

received in FY 2004. This small increment in the budget was not enough to cover the costs of inflation or the higher cost of new medical devices as they become available in the open market. VHA's unusually low increase from FY 2004 to FY 2005 means that VHA was under funded in FY 2005 by approximately \$150 million.

To compound the shortfall in funding situation, the increase in the number of unique patients that PSAS treats has shown a continuous upward trend. In FY 2002 PSAS treated 1,119,096 patients. In FY 2004 that number had increased to 1,383,658. Over the last three years the average increase in the number of uniques has been over 11 percent per year.

The vets returning from OEF/OIF require state of the art devices that VA purchases for them. Below is an estimate of the number of patients that PSAS expects to provide prosthetic services/appliances to in FY 2006.

- 18 completely blind
- 300 amputees
- 55 spinal cord injured
- 350 traumatic brain injury

These explanations point to some of the ways that PSAS will use the proposed \$100 million to continue providing quality care for our veterans.

PSAS, which has responsibility for all prosthetic funding, will distribute the funds to the facilities, based on a formula that utilizes historical data that includes special disability needs.

Question 21: Rates of Americans without insurance have climbed in recent years—from 14.6% in 2001 to 15.6% in 2003. Is there any evidence to suggest that this is not the case with veterans? Has VA assessed whether re-instating Priority 8 veterans might alleviate this problem?

Response: The percent of veterans without health insurance increased from 6.8 percent in 2001 to 7.3 percent in 2003, according to the current population survey. Veteran-specific rates are much lower than national rates because the national rates include uninsured children, and the veteran-specific rates reflect that veterans, as a group, are largely elderly (38 percent of all veterans are age 65 or over) and have Medicare coverage. About half of all enrollees in the VA health care system are age 65 or older and have Medicare.

Approximately 90 percent of all Priority 8 veterans have health insurance coverage of some type. We assume that this percentage also holds true for non-enrolled veterans who would otherwise fall into Priority 8. Therefore, since only 10 percent are uninsured, we believe that reinstating enrollment of new Priority 8 veterans would have minimal impact on the national rate of Americans who do not have health insurance.

Question 22: VA is proposing to cut research programs again in fiscal year 2006. What percentage of merit-review projects is it currently able to fund? How will the funding request for FY 2006 impact the VA's ability to fund merit-reviewed projects?

Response: VA currently approves 17 to 20 percent of its proposals for funding in a single review cycle. At present, 80 percent of the research budget is devoted to recurring and multi-year commitments – mainly research centers and studies. To meet newly identified veteran-centric needs, VA is transitioning to shorter durations of awards and is conducting competitive reviews of all centers to assure that a higher percentage of the annual appropriation is available annually for new projects. Currently, only 20 percent is available. The goal is to achieve an effective balance among the competing needs for research.

In addition to VA appropriations, the research program conducts important research supported by private and other public agencies (e.g., NIH and DoD). It is expected that funding from these non-VA sources will continue to increase in 2006, allowing for additional research project expansion.

Question 23: Even with a \$1.5 billion increase for fiscal year 2005, I have heard that some veterans integrated service networks may be projecting budget shortfalls. Is VA aware of networks that are projecting deficits this year and, if so, how will VA handle their requests for supplemental funding?

- A. Are VISNs converting non-recurring maintenance dollars into operating funds (for salary and other purposes)? Can you provide for the record information on equipment and non-recurring expenditures by VISN for FY 03, 04, & 05 and projected 06?
- B. I am also concerned that the FY 06 budget assumes a carryover from FY 05 and FY 06 of more than half a billion dollars. Are VISNs able to carry over those dollars or will this carryover in effect leave another hole in your budget?

Response: A. The Administration plans to send a 2005 Budget Supplemental to Congress shortly. The Administration also plans to send a 2006 Budget Amendment to Congress in the near future. All health care shortfalls in FY 2005 and 2006 will be addressed.

Response: B. Veterans integrated service networks (VISNs) that have un-obligated balances at the end of FY 2005 will be able to carry those funds forward for use in FY 2006. VISN and facilities are being challenged by continued patient demand growth. Most are gaining the efficiencies or taking the management actions required to operate within allocated funding levels while continuing to maintain the highest quality of care. Nonetheless, the flexibility to carry over funds from one fiscal year to the next helps to ensure that funds are effectively and efficiently expended on the highest priority needs for veterans.

Question 24: Congress will soon consider a supplemental appropriation for sustaining military operations in Iraq and Afghanistan. Should any additional funding for VA health care be considered as a continuing cost of war?

Response: A FY 2005 Budget Supplemental will be sent to Congress shortly which will provide sufficient funds to ensure that all veteran medical needs are met.

Question 25: Much of VA's purported increase comes from increased co-payments for veterans and improved collections—VA estimated that it would collect \$2.4 billion in fiscal year 2005; your current estimate for collections is \$2 billion—approximately 20% less than VA estimated. Why is this the case?

Response: The difference is a result of the proposed legislation (\$250 enrollment fee and \$15 pharmacy co-payment) that were not passed by the Congress.

Question 26: Please provide for the record the number of enrollees and the health care dollars spent in FY 04 by Congressional district.

Response: Enclosed is a spreadsheet titled, VA Health Care Enrollees and Expenditures for U.S. & Puerto Rico for FY 2004.

Question 27: Where is the list of VA's highest priority construction projects? When can Congress expect to receive it?

Response: The list of VA's top 20 major medical facility projects for FY 2006 can be found in the FY 2005 – 2010 VA 5-Year Capital Plan, Chapter 4, page 72. Copies of the plan were distributed to committee staff on February 18, 2005. The plan is also available on the internet at www.va.gov/oaem, under "Hot Topics". Below is an excerpt from the plan that provides the top 20 major medical facility projects.

FY 2006 Top-Twenty Major Medical Facility Projects

In accordance with section 8107 of United States Code 38, below are the top-twenty medical facility projects that were considered for the FY 2006 budget. These projects were ranked based on the CARES capital criteria.

VHA FY 2006 Top Twenty Major Projects

#	Location	Project Title – Brief Description	Priority Score	Estimated Cost (\$000)	Annual Cost (\$000)	Category
<i>The projects listed below were funded in phases in prior years and are therefore considered as top projects until funding is completed. Priority scores are from the FY 2004-2005 project scoring session.</i>						
1	Cleveland	OH Cleveland-Brecksville consolidation,	.4710	\$104,600	\$53,000	General

#	Location		Project Title – Brief Description	Priority Score	Estimated Cost (\$000)	Annual Cost (\$000)	Category
			phase 2				
2	Pittsburgh	PA	Consolidation of campuses, phase 2	.4532	\$190,800	\$181,000	General
3	Las Vegas	NV	New federal medical facility, phase 2	.3981	\$325,000	\$188,000	General
4	Gainesville	FL	Correct patient privacy deficiencies, phase 2	.3918	\$87,800	\$62,000	General
5	Denver	CO	New federal medical facility, phase 2	.3424	\$328,460	\$268,000	General
6	Orlando	FL	Bed tower, phase 2	.3314	\$253,600	\$82,000	General
7	Long Beach	CA	Seismic corrections buildings 7 & 126, phase 2	.3104	\$103,200	\$65,000	Seismic
8	Anchorage	AK	Outpatient clinic and regional office, phase 2	.2968	\$77,600	\$85,000	General
9	San Juan	PR	Seismic corrections-building 1, phase 2	.2888	\$149,700	\$198,000	Seismic
10	Los Angeles	CA	Seismic corrections- buildings 500 & 501, phase 2	.2536	\$79,900	\$96,000	Seismic
11	Lee County	FL	Outpatient clinic, phase 2	.2429	\$65,100	\$26,000	General
<i>The projects below are additional projects considered for the FY 2006 planning cycle. The priority scores are from the FY 2006 project scoring cycle.</i>							
12	Biloxi	MS	Consolidation- mental health center & clinical addition	.6284	\$174,600	\$23,000	General
13	American Lake	WA	Seismic corrections-NHCU replacement	.3285	\$34,200	\$810	Seismic
14	Palo Alto	CA	East Bay outpatient clinic	.3098	\$36,400	\$11,000	General
15	Dallas	TX	Clinical expansion & renovation	.3035	\$125,227	\$50,500	General
16	Fayetteville	AR	Clinical addition	.2962	\$56,200	\$75,600	General

#	Location		Project Title – Brief Description	Priority Score	Estimated Cost (\$000)	Annual Cost (\$000)	Category
17	Columbia	MO	Operating room suite replacement	.2617	\$22,600	\$5,350	General
18	San Francisco	CA	Seismic Corrections-Bldgs 1, 6, 8, & 12	.2571	\$57,600	\$54,000	Seismic
19	Madison	WI	Nursing home & older adult service realignment	.2528	\$11,500	\$14,000	General
20	Columbia	SC	DASCL and specialty care	.2503	\$38,200	\$96,000	General

Question 28: Please provide estimates for cost avoidance in pharmaceutical drug procurement from VA's use of the National Drug Formulary for FY 04, 05 and estimated FY 06.

Response: VA formulary management contracting activities provides an example of cost avoidance. To determine cost avoidance, VHA calculates the difference in price between the weighted average unit cost for drugs within a class prior to a contracting action and the weighted average unit cost of drugs in the same class after the contracting action. This cost difference is then applied to current volume to determine what VA's expenditures would have been had a contracting action not been completed. The following estimates of cost avoidances for FY 2004, FY 2005 and FY 2006 are provided:

FY 2004	\$360 M
FY 2005	\$330 M
FY 2006	\$300 M

While VA has been successful in its contracting activities for pharmaceuticals, it is likely that a decline in the cost avoidance savings will occur in future years. VA has contracted the major pharmaceutical drug classes that represent the highest cost savings opportunity. The greatest dollar savings in recent years has been gained from the use of generic contracts. Currently, VA use of generics is 64 percent.

Question 29: The Veterans Health Administration's Prosthetics and Sensory Aids Service administers the Home Improvement and Structural Alterations Program. Veterans Benefits Administration administers a different grant program for adapted housing. Explain the differences in these two programs, including the administration of each program, the eligibility for each program, and the benefits of each program.

Response: The major differences in the two programs is that the specially adapted housing grant is for building, buying or remodeling adapted homes or

paying indebtedness on those homes already acquired. The home improvements and structural alterations (HISA) benefit is provided to help pay for the cost of improvements and structural alterations necessary to ensure the continuation of treatment and/or provide access to the home or essential lavatory and sanitary facilities.

Specially Adapted Housing Grant

Under the authority of Chapter 21, title 38, U.S.C., Specially Adapted Housing for Disabled Veterans, VBA administers two housing grant programs for certain service-connected disabled veterans. Both grant programs are administered under the loan guaranty program.

Specially Adapted Housing (SAH) Grant: Under paragraph 2101(a) this grant of up to \$50,000 may be used to make a house accessible for a veteran whose service-connected disability is for loss or loss of use of:

- both lower extremities;
- one lower extremity plus blindness in both eyes;
- one lower extremity plus residuals of disease/injury;
- one lower and one upper extremity; or,
- both arms at or above the elbow.

In addition to basic eligibility for the grant, it must be determined that it is medically feasible for the veteran to reside in the proposed house, its cost bears a proper relation to the veteran's present and anticipated income and that it is suitable to the veteran's needs for dwelling purposes. A veteran may receive a SAH grant and a home improvement and structural alterations grant as long as funds are not used from one grant to pay for features already provided under the other.

Benefits Delivered: Since the beginning of the SAH program in 1948, over 32,000 veterans have used their eligibility resulting in distribution of grant funds totaling over \$565 million to either build new homes or adapt existing homes.

Special Housing Adaptation grants (SHA) Grant: Under paragraph 2101(b) this grant of up to \$10,000 is available to provide adaptations to meet the special needs of service-connected disabled veterans with:

- bilateral blindness with 5/200 visual acuity or less; or,
- loss or loss of use of both hands.

Home Improvements and Alterations Program

Title 38 United States Code (U.S.C.), Section 1717, is the statutory authority for the VA to provide home improvements and structural alterations (HISA) grants to eligible veterans. The HISA program is administered by VHA's prosthetic and sensory aids service strategic healthcare program and monitored to ensure appropriate funding and consistency in the administration of the HISA benefits.

Veterans receiving treatment from the VA under the auspices of 38 U.S.C., Section 1710 are eligible for HISA benefits as follows:

1. \$4,100 lifetime HISA benefit when necessary for: (a) service-connected condition; (b) non-service connected condition of a veteran rated 50 percent or more service connected, and (c) non-service-connected condition of a veteran in receipt of 38 U.S.C. Section 1151 benefits.
2. \$1,200 lifetime HISA benefit when necessary for treatment of a non-service-connected condition of veterans who are: (a) rated less than 50 percent service connected, (b) discharged or released from active duty for a disability incurred or aggravated in the line of duty, (c) former prisoners of war, (d) unable to defray the expenses of necessary care as determined under 38 U.S.C. Section 1722, e.g., veterans who qualify through "means testing", as determined via medical care cost fund (MCCF), (e) eligible for benefits under 38 U.S.C. Section 1710(a)(2)(F) and (e), due to exposure to a toxic substance, radiation, or an environmental hazard, (f) veterans who are required to pay a co-payment for their care are eligible for the \$1,200 benefit due to enactment of Public Law 105-114, Section 402(b)(2).

Benefits Delivered: The HISA benefit is limited to the improvement and structural alterations necessary only to assure the continuation of treatment and/or provide access to the home or to essential lavatory and sanitary facilities. It does not include those improvements which would serve only to lend comfort to the individual or make life outside the health care facility more acceptable.

Question 30: Sec. 8 of P.L. 107-95 required that each of VA's primary care health care facilities develop a plan for providing, directly or by contract, mental health services. What direction has gone to these centers regarding implementation of this requirement? Has this requirement improved rural veterans' access to such services? If so, how?

Response: VA implemented a performance measure this year requiring that 85 percent of community based outpatient clinics (CBOCs) with greater than 1,500 unique patients have at least 10 percent of their total visits are with specialty mental health providers. This direction was given to the network directors by the Deputy Under Secretary for Operations and Management in a memo dated October 1, 2004. This measure is already improving mental health access at CBOCs. VHA has made substantial progress in a short period of time. VHA has gone from a baseline score in FY 2004 of 70 percent, to 73 percent in the first quarter of FY 2005, and a score of 77 percent in the second quarter of FY 2005. In summary, VHA is making great strides in ensuring that mental health services are provided to veterans in CBOCs, many of which are in rural areas.

Question 31: Mr. Secretary, I have a series of questions regarding the savings estimate that you base on management efficiencies. How confident are you in this

\$1.8 billion "subtraction" from the budget? After all, if your Administration does not deliver – veterans will be short changed by almost 2 billion dollars – would you call that significant?

Response: First of all, yes, we agree that savings from management efficiencies are a significant part of our overall budget request. But, VA has used management efficiencies in the past and will continue to monitor and emphasize the need for performance that results in minimizing unit costs where possible, and eliminating inefficiency in the provision of quality health care. The \$1.8 billion in management efficiencies is composed of recurring and anticipated new efficiencies in standardization of pharmaceuticals and supplies, inventory management, productivity, administrative/clinical consolidations, and VA/DoD sharing.

Question 32: Mr. Secretary, in the FY 2004 Budget Submission, VA estimated management savings of \$950 million to partially offset the overall cost of health care. If VA did not anticipate savings through management efficiencies, VA would have likely received almost one billion dollars more for veterans health care. That estimate was accepted at face value and was based on implementation of a rigorous competitive sourcing plan, reforming health care procurement, increasing employee productivity, shifting from inpatient to outpatient care, reducing employee travel, interagency motor pools, maintenance and repair services, and operating supplies. Now that FY 2004 is behind us, we should be able to look back and assess the accuracy of that estimate. Do you agree?

Response: VA does agree, and is pleased that VA did meet its FY 2004 goals in management efficiencies, as outlined in the following table:

Category	FY 2004
Recurring efficiencies from prior year	\$316 million
Standardization of pharmaceuticals	\$380 million
Standardization of other supplies / materials, equipment & inventory management	\$104 million
Productivity	\$28 million
Administrative consolidations, VA/DOD sharing, and other	\$122 million
Total	\$950 million

Question 33: In April 2003 VA General Counsel determined that VHA had limitations in law preventing a robust competitive sourcing plan. In FY 2004 VHA did almost no competitive sourcing, a principal basis for the savings estimate –

although even the assertion that competitive sourcing saves money over the long-term is suspect. However, the fact that there was no competitive sourcing would impact the estimate, would it not?

Response: Competitive sourcing was suspended in late FY 2003. Hence, competitive sourcing did not result in savings in FY 2004. If VA were able to use competitive sourcing as a mechanism to increase efficiency, we believe that savings would be significant.

Question 34: The 2004 estimate also speaks to health care procurement, but the IG has found over 25 million in pre and post award contract audits. Additionally, an audit of major construction contracts notes a VA risk for excessive prices in the \$133 million dollar range and notes potential fraud involving certain contract award actions. Do you think that these are the basis for the management efficiencies? It sounds like just the opposite to me.

Response: The functional areas designated for management savings/cost avoidance in FY 2006 include standardization of contracts primarily in the areas of pharmacy, medical supplies, and equipment. Pharmacy alone reported about \$380 million in cost avoidances during FY 2004. Major construction was not a specific area identified for FY 2006 management savings, however, any actual savings/cost avoidance in this area would aid in achieving the budget goals.

Question 35: A Nov. 4, 2004 independent audit by Deloitte and Touche noted that Operational Oversight in the VHA was a repeat condition requiring attention. The audit notes continued non-compliance with certain established policies and procedures important to maintain internal controls. How does that equate with being savings through management efficiencies?

Response: Effective and efficient operational oversight combined with a strong system of internal control is always a desirable goal in any organization. Operational principles such as separation of duties help prevent waste and mismanagement. VA is working to continually improve in the above areas as recommended by Deloitte and Touche. However, there are no specific savings associated with these improvements.

Question 36: The same Deloitte and Touche report, names the Integrated Financial Management System of VA once again as a Material Weakness – a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. This is a repeat write-up. Does that sound like performance contributing to almost a billion dollars in management efficiency savings?

Response: VA has and is continuing to take steps to address and resolve this material weakness. VA has not only received an unqualified ("clean") audit

opinion for the past six years, but VA met OMB's earlier November 15 reporting date one year ahead of schedule. VA realizes the process used by VA to assemble the consolidated financial statements is still cumbersome, but VA continues to make improvements, particularly in the preparation of the compensation and pension liability estimate as well as the medical liability actuarial estimate. In addition, VA has tasked the financial systems support contractor, in partnership with the financial reporting staff, to implement an automated financial statement reporting system, leveraging a system developed by another Federal agency that uses the same core financial system software

Question 37: Undoubtedly VA has management efficiencies that would pass muster. However, VA managers have also made some significant errors as well. Near the end of the 06 Budget Submission Summary, volume #4 of 4, about 7 printed pages from the end of this last document, we find mention of the failed coreFLS system. This write-up in your Budget does not mention the wasted quarter of a billion dollars in obligated funds for an unsuccessful system. This Administration's Budget does not mention bad project management of coreFLS when it claims savings through management efficiencies. It only refers to "technology and other issues" as the reason to phase out the project. The VA IG's August 11, 2004, report is somewhat more succinct--"VA's management of the coreFLS projects did not protect the interests of the government."

Response: VA has acknowledged that errors occurred with the core financial and logistics system (coreFLS) pilot test, and steps the VA has taken to address those are a matter of record. On July 13, 2004, the Secretary announced his decision to move the coreFLS project from the Office of the Assistant Secretary for Management to the Office of the Assistant Secretary for Information and Technology and establish the VA coreFLS board of directors as the mechanism for key decision making on go forward issues. The membership includes the most senior leaders in VA, including the chief information officer, the chief financial officer, and the under secretaries. Subsequent to forming the board, on July 26, 2004, the Secretary announced the decision to phase out the coreFLS pilot program designed to test the integrated financial and logistics management system at the Bay Pines Medical Center and two focus sites, the National Cemetery Administration and Veterans Benefits Administration .

Further, VA's project management certification and training program was established to address the need for skilled and credentialed project managers. The program includes standardized project management guidelines and procedures to ensure project success. It is designed to provide relevant training to project managers, equipping them with the knowledge and understanding necessary to achieve successful results. Program courses include the entire project management body of knowledge and are widely considered the industry best practice.

Currently, tasks are underway to evaluate VA's financial and logistics business processes. On December 15, 2004, PricewaterhouseCoopers was awarded competitive procurement, firm fixed price contract to:

1. Analyze the "as is" business processes;
2. Identify specific actions to be taken to resolve the FFMIA material weakness, "Lack of an Integrated Financial Management System";
3. Develop "to be" finance and logistics business processes that will form the basis for how VA intends to do finances in the future. The "to be" or future business processes will have to reconcile back to the "as is" condition to ensure that current state has a target, future state; and
4. Identify potential solutions including commercial and government off-the-shelf software, and the financial management line of business.

This effort has concluded and the coreFLS board of directors has been briefed on results. Decisions will be reached regarding standardization of business processes across the VA enterprise shortly. Integrated systems issues and acceptable products will then be addressed at that time.

**Questions for the Record
Honorable Lane Evans
Committee on Veterans' Affairs
February 16, 2005
Hearing on Department of Veterans
Affairs
Fiscal Year 2006 Budget**

Question 8- Attachment

**DRAFT: Comprehensive Project
Management Plan for VETSNET**

Department of Veterans Affairs Veterans Benefits Administration



Veterans Service Network VETSNET

Project Management Plan

Project Name	Project Reference Number	Prepared By	Preparer's Initials
Veterans Service Network	None	VBA PMO	NIL
Managing Organization	Contact	Contact's Phone	Date Prepared
VBA OIM	Pamela Zadak	(708) 681 - 6773	February 23, 2005

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Preface

This Project Management Plan (PMP) updates and outlines the strategy and framework supported by processes, procedures, schedules, and reports that will collectively ensure successful management of VBA's Veterans Service Network (VETSNET).

The PMP includes management baselines required to compare actual project performance against the original plan.

The PMP is maintained by the respective Project Team (PT) and is updated as project changes warrant. All personnel assigned to the project are provided a copy of the PMP and are responsible for implementing and adhering to the policies and procedures contained in the PMP.

This PMP is an update to the previous VETSNET Project Management Plan dated January 10, 2003. It incorporates programmatic updates needed to reflect the current management strategies, technical development strategies, and overall implementation strategies based on the successful deployments of key VETSNET application suite features and capabilities as well as the ongoing plans for additional VETSNET production testing and full scale deployment.

The PMP is evolutionary in design and intent, and will be updated to include lessons learned from each major milestone accomplishment. The primary emphasis is on the importance of minimizing or eliminating adverse impacts to veterans and to the VBA workforce, as well as the importance of training and deployment preparation, including how to add records systematically at each Regional Office (ROs), how to systematically add ROs with the least possible disruption to the claims processing workload.

Executive Summary

The Veterans Service Network (VETSNET) is a system of integrated applications to replace the Benefits Delivery Network (BDN). BDN is a legacy system that has been used several years by the Veterans Benefits Administration (VBA) to process and pay claims for VBA benefits.

Three of the five major applications of VETSNET are already being used in all Regional Offices (RO) as the basis for claims processing (i.e., Search and Participant Profile, which records and updates basic information about veterans and their dependents; Modern Award Processing-Development, which develops the claim and Rating Board Automation 2000, which rates the claim).

All five VETSNET applications (including Award, which prepares the award and the Financial Accounting System, which pays the claim) are being used by the Lincoln and Nashville ROs to pay electronic funds transfer disability compensation claims for veterans with dependents who are rated from 10% through 100% (except for apportionment). VBA is planning to complete full deployment of VETSNET to all regional offices by December, 2006.

This Project Management Plan is a key component of an overall VBA commitment to improved management oversight of a critical business asset, the Veterans Service Network. The primary goal of implementing VETSNET is to minimize or eliminate all adverse impact to veterans and their dependents and to the VBA workforce during the transition from BDN to VETSNET.

This goal is consistent with VBA's intent that the processing of claims in the most timely manner possible remains the highest priority of VBA. Accordingly, VBA has developed a systematic approach to VETSNET that is based on lessons learned from (1) previous development and deployments of VETSNET applications, (2) CoreFLS and (3) analyses of the Federal Bureau of Investigation Trilogy project.

This systematic approach has included upgrading the legacy system (Benefits Delivery Network or BDN) so that BDN could remain operational and as reliable as possible until VETSNET is fully deployed and in use by all regional offices. This effort was based on the recommendations from the Claims Processing Task Force to develop an "insurance policy" for BDN. It included upgrades of the BDN hardware and software, simplification of the BDN job streams and the payment of retention bonuses to key individuals at the Hines Information Technology Center (ITC) in order that VBA would have qualified workers for legacy system support. Also, in order to simplify the workload of the Hines ITC, we have reduced the number of releases of new software by scheduling them on a quarterly rather than monthly basis.

VBA has systematically and methodically introduced the new VETSNET applications into the VBA workforce in an orderly fashion that corresponds to the steps in the claims processing work flow. From the technical perspective, these applications have been developed with input from the end users and business lines and have been extensively tested by independent contractors, business line users and also end users in regional offices. Furthermore, as these VETSNET applications have transitioned from development into deployment and use in the regional offices, responsibility for their operation and maintenance has been transferred to the Hines ITC.

From the business perspective, these applications have been systematically introduced into the workforce in such a way as to minimize the adverse impact to the workforce. This introduction has included systematic training of key individuals and the methodical insertion of the new applications into the claims processing workflow.

This Project Management Plan is focused on the completion of the remaining milestones necessary for successfully achieving the goal of full VETSNET deployment to all regional offices by December, 2006. The three major elements of this are (1) planned quarterly releases to deploy full VETSNET functionality to all regional offices, (2) training of the VBA workforce in order to accomplish the successful absorption of this new technology and (3) deployment preparation to ensure that all regional offices successfully absorb this new technology with the least possible adverse impact on veterans and the VBA workforce.

Individual portions of this Project Management Plan address the following specific areas of VETSNET: (1) VBA's approach in deploying VETSNET, (2) VETSNET management strategy, (3) internal controls, (4) schedule, (5) training, (6) cost management, (7) risk management, and (8) communications plan.

Approach

Overview

The Veterans Service Network (VETSNET) is a system of integrated applications to replace the Benefits Delivery Network (BDN). BDN is a legacy system that has been used several years by the Veterans Benefits Administration (VBA) to process and pay claims for VBA benefits.

The primary goal of implementing VETSNET is to minimize or eliminate all adverse impact to veterans and their dependents and to the VBA workforce during the transition from BDN to VETSNET. This goal is consistent with VBA's intent that the processing of claims in the most timely manner possible remains the highest priority of VBA. Accordingly, VBA has developed a systematic approach to VETSNET that is based on lessons learned from (1) previous development and deployments of VETSNET applications, (2) CoreFLS and (3) analyses of the Federal Bureau of Investigation Trilogy project.

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From the business perspective, these applications have been systematically introduced into the workforce in such a way as to minimize the adverse impact to the workforce. This introduction has included systematic training of key individuals and the methodical insertion of the new applications into the claims processing workflow.

As a result of this combined technical and business line approach, VBA is now deploying the last two VETSNET applications, using all the lessons learned from all the sources mentioned above. Throughout this process, VBA has continued to identify and mitigate or eliminate risks associated with the introduction of new applications into the VBA workforce.

Additionally, we have tried to balance the technical effort in such a way that the Hines ITC has increasingly responsible roles for the operation and maintenance of VETSNET applications. Furthermore, the overall role of the Hines ITC has been expanded significantly because of efforts after September 11, 2001 to ensure disaster recovery, continuation of operations and continuity of government.

In summary, VBA is continuing its efforts to transition systematically from BDN to VETSNET in such a way that causes the least disruption possible to our veterans and workforce, including the Hines ITC.

Goals

The primary mission of the Department of Veterans Affairs is to "honor, compensate, and care for veterans in recognition of their sacrifice for America." One of the most direct ways in which the Department achieves this mission is through the award and payment of benefits to veterans in the form of compensation and pension (C&P) benefits. VETSNET represents a system for providing automated support to the award, payment, and associated accounting functions for VBA's C&P program. VBA provides 42 million payments to approximately 3.1 million veterans and their dependents annually. Furthermore, VETSNET closes the circle of redesign efforts for the end-to-end C&P claims processing cycle: from initial claim application through review, rating, and adjudication to the award and FAS process.

In addition to the clear and direct support that this initiative provides in serving a significant number of veterans, the C&P Replacement System will also assist

VBA and C&P in performing required recording and monitoring functions to support financial management at both the Administration and Departmental levels. The proposed system will accept the results of the claims adjudication process, calculate and support timely approval of award amounts, generate required payment transactions through Treasury for timely issuance of payment checks and electronic funds transfers, generate the associated audit trail for those payment transactions, and provide automated support for reconciliation, reporting, payment inquiries, and other critical information management functions.

This initiative is necessary to replace the current C&P Benefits Delivery Network (BDN) functionality that does not support compliance with federal financial management regulations, does not provide automated support for adequate control over payment processing, and does not support critical customer service needs such as immediate response to payment inquiries and immediate feedback regarding processing errors to allow timely corrections and processing of appropriate payment amounts. The existing system has as its foundation an outdated and complex command driven platform, with negative implications for long-term system life-cycle support (only user of proprietary software and equipment). Furthermore, over the next 3 years VBA's Office of Information Management (OIM) will face a shortage of personnel who are qualified to maintain the legacy system since over half of its personnel are eligible for retirement. Finally, the proposed investment in information technology support for these functions will bring benefits processing for C&P into alignment with broader strategic objectives and information technology standards of the Department and will support wider access to and use of information associated with the processing of C&P payments.

Objectives

When complete, VETSNET will:

Establish the Claim

- Store information in Corporate Database

Develop the Claim

- Provide On-line access to case status information
- Develop using Rules-based techniques
- Provide Intranet Workload Management Reports

Rate the Claim

- Provide rating data accessible by stakeholders
- Provide reusable Data for supplemental ratings
- Record Actual and accurate diagnosis
- Provide simultaneous access to veteran info

Prepare the Award

- Provide on-line transaction edits and internal controls

Notify the Veteran

- Generate award letters and correspondence

Pay the Veteran

- Generate payment files

Record and tracks payment information

Management Strategy

VETSNET has been identified by the Under Secretary for Benefits as the highest priority information technology initiative in VBA. Consequently, the entire leadership of VBA is regularly involved with VETSNET issues. Overall management of VETSNET is assigned to the VETSNET Program Manager. This role is supplemented and complemented by the individuals, organizational components and boards described in more detail under the Roles and Responsibilities portion of this document.

In addition to these specific roles and responsibilities, the Deputy Under Secretary for Benefits and the VA Deputy Chief Information Officer attend weekly meetings of the VETSNET Executive Board (VEB). Additionally, the VEB updates the Under Secretary for Benefits on a regular (normally weekly) basis.

VETSNET application's development, maintenance, testing, and field deployment occur within an integrated program management structure. Integrated Project Teams (IPT) are located in the Hines, IL Information Technology Center (ITC); the Austin TX, Systems Development Center (SDC) and the St. Petersburg FL, Systems Development Center.

Typical of this approach, the St. Petersburg Systems Development Center is responsible for IT development activities including the development of AWARD and FAS components of VETSNET. The Center maintains the VETSNET Architecture and conducts and supervises application testing.

The following table identifies the IPT projects and the associated development center.

IPT Project Focus	Sub Projects	Supporting Center
Architecture	Architecture, Capacity Planning	St. Petersburg SDC
Conversion	Conversion and Utilities	Hines ITC
Deployment Planning	Deployment, Implementation	St. Petersburg SDC, VACO
Operations and Maintenance	Operations Management	Hines ITC
Program Management	Program Management	Hines ITC, St. Petersburg SDC, Austin SDC, and VACO
Security	Security	VACO
Software Development (OLTP)	Award and Correspondence Finance and Accounting System (FAS)	St. Petersburg SDC
	Modern Award Processing Development (MAP – D)	Hines ITC
	Rating Board Automation 2000 (RBA 2000)	
	Conversion Interfaces	Austin SDC
	Synchronization (Share)	
	Search and Participant Profile (SPP)	
Software Development (Utilities)	Utilities (Batch)	Austin SDC
	Interfaces	
Testing	Applications Testing	All
Training	Training	All, VACO

The complexity of the development effort and the geographically distributed nature of program are managed and directed by the VETSNET Program Manager and the individual site location Leads. This core management group comprises the VETSNET Project Management Office (PMO). The PMO monitors software development efforts, applications testing, and field operations of the VETSNET architecture. The PMO plans life cycle management efforts and conducts software release planning. The PMO is essential to effective management within the Integrated Program Management approach.

Project Control Board (PCB) members will be responsible for supporting the project with timely managerial decisions and facilitating the access to needed business line subject matter experts (SMEs).

The PT will perform all other necessary work represented in the attached Work Breakdown Structure (WBS) using the management strategies and controls outlined in this PMP.

Roles and Responsibilities

Key Roles and Responsibilities

Key roles and responsibilities are described below:

- Director, C&P Service and Chief Financial Officer (CFO). Business sponsors and the primary advocates for the VETSNET projects.
- Business Sponsor Project Manager. Designees of the Director, C&P Service and CFO with responsibility and authority to manage the C&P business development and functional task areas, to coordinate business efforts within the VBA and to coordinate with the Technical Project Manager to ensure that the technical efforts are consistent with the business requirements.
- Deputy Chief Information Officer for Benefits. Technical sponsor for the project and is responsible for ensuring the implementation of VETSNET.
- Technical Program Manager. Designee of the Chief Information Officer. As Director of the VACO VETSNET IPMO, he or she has responsibility and authority to manage the technical aspects of the development and functional task areas, to coordinate technical efforts within the VBA and to coordinate with the Business Sponsor Project Manager to ensure that the technical efforts are supportive of the business requirements.

- St. Petersburg, FL Project Teams. Project Manager for the Systems Development Staff. The following subproject teams function under his or her direction:
 - Search and Participant Profile
 - Award and Correspondence
 - Finance and Accounting System (FAS)
 - Testing
- Hines, IL Project Teams. Designee of the Director of the Systems Development Staff manages the Hines, IPMO. The following subproject teams function under his/her direction:
 - Utilities (Batch) and Interfaces
 - Conversion
- Director of the Hines Benefits Delivery Center, oversees:
 - Operations Management
- Austin, TX Project Team. Designee of the Director of the SDC. The following team functions under his direction:
 - Synchronization (Share)
- VACO Office of Information Management Project Teams. Subproject teams include:
 - Architecture
 - Capacity Planning
 - Program Management
 - Security
- VACO Office of Performance Analysis and Integrity Project Teams. Project teams include:
 - Reports

VETSNET Executive Board

In addition to these key functional roles and responsibilities, the VETSNET Executive Board (VEB) provides executive direction to the VETSNET program. The VEB is responsible for the corporate commitment required to effectively deliver VETSNET components, including the provision of the appropriate level of VBA management support to ensure the success of the program.

The VEB reviews the VETSNET program status, provides coordination for required resources, and decides VETSNET issues and matters needing resolution at the VEB level.

The VEB advises the Deputy Under Secretary for Benefits and makes recommendations to the DUSB regarding Board level issues and matters, such

as those arising from the Project Control Board or from any VBA component participating in the VETSNET program.

The VEB membership includes:

Co-Chairs: Establish and facilitate the Working Groups agenda; recommend priorities for the Executive Board; act as liaison to the VETSNET Project Control Board.

Responsibility: The Associate Deputy Under Secretary for Field Operations serves as the End User Co-Chair.

Responsibility: The Deputy Chief Information Officer for Benefits serves as the Technical Co-Chair.

Business Principal: Primary advocate for VETSNET's business responsibilities; executive communication intermediary between the business lines and USB/DUSB and staffs. Determines membership, attendance and participation of business sponsors under his or her supervision.

Responsibility: The Associate Deputy Under Secretary for Policy and Programs.

Business Sponsors: Liaisons with Business project managers to identify and address project business/business sponsor resource demands; recommend resolution strategies/options, reports on outcomes.

Responsibility: Director, Office of Resource Management (VBA Chief Financial Officer)

Responsibility: Director, Compensation and Pension Service. Membership, attendance and participation are based on and consistent with the recommendations of the Business Principal as well as the phase of VETSNET being addressed by the VETSNET Executive Board.

Responsibility: Director, Education Service. Membership, attendance and participation are based on and consistent with the recommendations of the Business Principal as well as the phase of VETSNET being addressed by the VETSNET Executive Board.

Responsibility: Director, Vocational Rehabilitation and Employment Service. Membership, attendance and participation are based on and consistent with the recommendations of the Business Principal as well as the phase of VETSNET being addressed by the VETSNET Executive Board.

Business Support Sponsor: Liaisons with Business support project managers to identify and address project business support sponsor resource demands; recommend resolution strategies/options, reports on outcomes.

Responsibility: Director, Performance Analysis and Integrity

Field Sponsor: Liaisons with Field project manager(s) to coordinate function between the VETSNET business/technical elements and field operations; coordinates VETSNET training activities, serves as information dissemination point or origin, as well as represents the control official for field resources.

Responsibility: Associate Deputy Under Secretary for Field Operations

Technical Sponsor: Responsible for ensuring the technical implementation of VETSNET.

Responsibility: Deputy Chief Information Officer for Benefits

VETSNET Program Execution:

Responsibility: VETSNET Program Manager

Further clarification of the responsibilities of the VEB may be found in the VETSNET Executive Board Charter dated September 1st, 2004.

VETSNET Project Control Board

In support to these key functional roles and responsibilities, the VETSNET Project Control Board (PCB) is co- directed by the Business Project Manager and the Technical Project Manager, and consists of other supporting functional team leaders. The PCB is responsible for the delivery of the project. The PCB meets as needed (weekly) to conduct the following activities:

- Provide project and subproject status and updates as they relate to cost, schedule, and performance.
- Assess the status of ongoing initiatives and determine corrective action;
- Maintain the consolidated Project Management Plan (PMP);
- Analyze and review proposed changes to the project and assess the impact on project delivery schedule;
- Brief and elevate issues to the VEB as necessary.

The PCB will elevate to the VEB all issues that cannot be resolved within the PCB's span of control and authority.

Further clarification of the responsibilities of the VEB may be found in the VETSNET Project Control Board Charter.

VETSNET Change Control Board

In addition to these key functional roles and responsibilities, the VETSNET Change Control Board (CCB) is an advisory board that reviews, approves, and

prioritizes changes to the VETSNET software, supporting documentation, and software problem reports. The CCB oversees changes including all proposed enhancements (also known as a "Design Change Request" or DCR is a change to revise the functionality or design of the application) and any defects (application functionality that is inconsistent with approved functional specifications) that meet the following conditions:

- Sponsor and developer do not agree whether a VBA Change Request (CR) results in a defect or enhancement
- Sponsor and developer do not agree whether or not a defect actually exists
- Sponsor and developer do not agree on the defect's required priority or schedule

The CCB is an adjunct to the VPCB and does not have a direct reporting relationship to the VPCB. However, the CCB will elevate to the PCB all issues that cannot be resolved under the CCB's span of control and authority.

A description of the CCB and its processes and reporting procedures may be found in the VETSNET Change Control Board Charter and the VETSNET Project Charter dated September 1, 2004.

Internal Controls

Control will comply with the Department of Veterans Affairs (VA) Office of Information and Technology Project Management Guide. Project control involves regular reviews of project status to identify variances from the planned baseline and taking corrective action when necessary to ensure that project objectives are met. The core control processes implemented during this project phase are Performance Reporting and Integrated Change Control.

The Integrated Change Control process is the direct responsibility of the CCB.

Schedule

Schedule Overview

The schedule will provide the primary means for tracking and managing the VETSNET project. It will fully describe the activities required to develop and implement the VETSNET technologies for field production use.

A VETSNET Program Level Milestone Plan has been laid out to ensure that all critical functions are being integrated and addressed in the proper sequence in order to maximize the effectiveness of available resources, including all project teams. These functions include: (1) On Line Transaction Processing, (2) Utility Processing, (3) Conversion, (4) Reports, (5) Integrated System Testing, (6) Security, (7) Testing – Sponsor, (8) Testing – Users, (9) Training, (10)

Deployment Preparation, (11), System Architecture and (12) Operations and Maintenance.

Recently completed major milestones include the May 10, 2004 beginning of live field testing of VETSNET in production at the Lincoln Regional Office and the beginning of live field testing in production at the Nashville Regional Office in February, 2005. Based on the successful completion of these milestones, the VETSNET schedule is currently being updated to meet the goal of full deployment to all Regional Offices by December, 2006.

The successful completion of training and deployment preparation milestones will be used as the basis for determining other functional milestones. Additionally, increased functionality is being systematically added to VETSNET through quarterly releases. Therefore, quarterly releases, training and deployment preparation are central to all VETSNET scheduling.

Individual project schedules may be developed for the separate functions of acquisition support, software development, software functional and end user acceptance testing, and implementation to the Regional Offices and beta test facilities. The PCB may direct the development of supporting schedules as needed.

A detailed VETSNET Program-Level Milestone Plan is also maintained by the VETSNET PMO.

Each schedule, including the VETSNET Program-Level Milestone Plan, will be submitted as an addendum to this PMP.

Schedule Development

Primavera IT Project Office (formerly known as TeamPlay), an automated scheduling tool, will be utilized on this project. Initially, the PT will develop a preliminary integrated schedule. That integrated schedule will be based on the detailed WBS referenced in Attachment "A." The duration of the activities (work) will then be estimated and the resources needed to accomplish each task will be identified.

Constraint/predecessor relationships will be built into the schedule as necessary. The schedule will be reviewed by all project participants and adjustments made by the PM with assistance from VBA's PMO. Once all participants have reviewed the project schedule and have agreed to the individual tasking, the schedule will then be baselined. Timely schedule development and management is the responsibility of the PCB.

Schedule Control

Once the schedule has been baselined, participants identified in the schedule will provide status, updates, and issues for their assigned tasks to the PM and subsequently to the PCB on an as needed basis.

The current schedule will be compared to the baseline schedule and VBA's PMO will provide analysis to the PM. The schedule will be kept electronically by the PMO as a separate document to this plan and referenced as Attachment "B."

Project participants, PCB members, CCB, and VEB members may view up to date site specific project schedule data via a published project web site.

Training

Training Strategy

Based on lessons learned from the previous deployment of VETSNET applications and from CoreFLS, VBA's training strategy is based on the use of mandatory, live, hands-on training for VETSNET as compared to computer based training and videos for CoreFLS.

The approach and methodology to VETSNET training will be to train a group of "super users"—at least two in each regional office (one for Post-Determination and one for Finance). The training will then cascade to all other employees needing to be trained. The super users will be trained in centralized locations by Compensation and Pension (C&P) and Finance instructors. C&P and Finance Services will develop the national training curriculum and materials for training VETSNET Awards and FAS super users. The super users for training others back in their respective regional offices will in turn use that curriculum and materials.

A certification tracking system is recommended to document training completed for each Post-Determination and Finance employee who will use either VETSNET Awards or FAS. Regional offices will be required to provide reports of training progress to C&P Service and Office of Resource Management (ORM), which will maintain VETSNET training records for all offices.

Training Management Plan

This VETSNET Awards and FAS Training Management Plan details the steps to be taken to ensure successful transition from the Benefits Delivery Network (BDN) to VETSNET for awards processing and FAS. The training curriculum will be developed with the support of independent contractors. C&P subject matter experts will design and develop the program using instructional systems development (ISD) principles. Contractor support will assist in grouping and sequencing the curriculum for maximum learning effectiveness and to review developed materials for instructional soundness and instructional integrity.

This Training Management Plan calls for a help desk, satellite broadcast, desk reference guide, user's manual and other job aids to assist in the learning and ensure a smooth and seamless transition.

Cost Management

This section describes cost and budget considerations and the process to report status and cost information for the project. This information will be available to and used by the VETSNET team leaders to understand how they are interrelated and how VETSNET resources are being used.

Cost and Budget Overview

VBA Office of Information (OIM) will be responsible for the annual recurring and maintenance costs associated with developing the VETSNET system. Additionally, with the support of the Business Sponsors, OIM will refresh the Exhibit 300 as needed.

Cost Control

The actual costs of the project will be reported and compared to the budgeted costs monthly. This information will be limited to the PM, PCB, VEB, and other parties on an as needed basis. IT Project Office will be used to track project costs and expenses. The budget cycle will be used to plan the future costs of maintenance of the VETSNET applications and planned enhancements.

Risk Management

The process of identifying, allocating, managing and minimizing risks is crucial to the success of VETSNET. The ability of the PM to track and understand various risks and then to allocate resources to mitigate them will be a major factor in bringing the project in on time and on budget. The following steps identify the procedures for identifying and tracking VETSNET risks. Identified risks will be tracked using the Risk Assessment Form for Initiative (see Attachment "C") maintained and updated in IT Project Office.

Identified risks and mitigation activities will be addressed at each status meeting with special attention given to risks directly related to project activities currently in progress or anticipated to start prior to the next status meeting.

Risk Identification

As VETSNET progresses, it is assumed that aspects of it will change and evolve. Consequently, the risks that were first identified in the planning phase may be magnified, reduced, or disappear while others surface and must be addressed. Currently, one focus on VETSNET is the area of deployment risk management. Any member of the PT can identify a new risk by completing the Risk Assessment Form for Initiative. This form will ensure a uniform, disciplined approach to documenting risks identified. The use of IT Project Office will provide an automated method of recording and tracking risks. A current risk list is maintained in the Exhibit 300.

Risk Assessment/Quantification

Once identified, the risk will be analyzed and quantified by the PM and the PCB. The PM in association with the PCB and subject matter experts will assign a probability of occurrence and a potential project impact should the risk occur.

The qualitative values for probabilities and impacts:

<u>Probabilities</u>	<u>Impacts</u>
High (Very Likely)	High
Medium (Probable)	Medium
Low (Possible)	Low

Risk Allocation

Once risks have been identified, they will be assigned to specific team members for monitoring. If the risk does manifest, the team member assigned to the risk, or risk owner, shall alert the PM. Upon receiving guidance from the PM, the risk owner will be responsible for application of the identified mitigation strategies.

Risk Containment

At the direction of the PM, mitigation plans will be developed for each identified risk. The PM is responsible for overall risk and mitigation analysis and prioritization. The prioritization process will be useful in ensuring the number of strategies competing for resources will be manageable. Risks will be monitored across the project lifecycle.

Currently Identified Risks

The following table summarizes the currently identified **high** risks and who "owns" the risk. All risks are detailed and managed in IT Project Office. They may be found in the Exhibit 300.

[illegible]

Communications Plan

The distributed locations of project participants, participating organizations as well as key management support dictates that the PCB explicitly plan, prepare, and distribute timely project communications. In fact, under such circumstances, proper communication planning is a key factor for the overall success of the project.

In order to facilitate communication among all these varied participants, VBA uses a complete set of tools including a VETSNET Web page, Dimensions, Process Max and other common development tools.

Communication Plan

The Communication Plan (CP) establishes the processes, methods, tools and standards to ensure clear and effective communication to all project stakeholders. Official project scope, plans, technical documentation and status information will be managed under this CP.

The CP will describe the "Who", "What", "How" and "How Often" project information will be collected, maintained and distributed to all participant levels. Appropriate detail about "What" may include information regarding:

- Deliverable evaluation
- Collaboration/idea generation
- Issue and Risk resolution
- Project performance assessment
- Funding

Appropriate detail about "How" may include information regarding the use of:

- VEB/ PCB/ CCB/ PT Meetings
- Project Status Reports
- Technical working groups
- Change Control Mechanisms

Appropriate detail about "How Often" may include information regarding:

- Weekly Updates
- Bi-weekly Updates
- Management Reviews

The CP identifies the project member directly responsible for the development and distribution of the appropriate information. The CP includes stakeholder management, project data management and project reports.

Stakeholders and Organization

A stakeholder is anyone positively or negatively impacted by the outcome of the project. This section documents the key stakeholders for this project. The key stakeholder group is organized into units for the purpose of information distribution.

The Project Key Stakeholder Chart is listed below ?????. The chart illustrates how the project's key stakeholders relate to each other for the purpose of this project. This chart displays who is involved in the project and how information should flow.

In addition to the listing of Project Key Stakeholders, a site specific stakeholders listing will be prepared for each individual telephone system ????effort and provided in the site specific project plan addendum.

Data Sets and Tracking Tools

Project information will be developed, collected, documented, tracked and stored by the PCB with input from the stakeholders. Project information includes the Scope Statement, PMP (i.e., the WBS, Project Schedule, CP, Risk, and Cost Control plans), Issues/Risks logs, contract documentation, reports, minutes, analyses and any and all other data pertinent to the management of the VETSNET Project.

Specified project data will be stored and maintained by the PCB. The primary data tracking and reporting tool is IT Project Office. This application will house all task, schedule, resource and cost data. The VBA PMO will maintain the schedule on a weekly basis with inputs from the VEB, PCB, CCB, and other key stakeholders. The information will be updated in IT Project Office within 1 week from the Project Status meeting.

Reporting Process

Project Reporting is designed to deliver relevant, timely, and targeted project information to stakeholders. It is the goal of the VETSNET project to provide open access, a wide distribution of information, and foster two-way communication at all levels of the organization. The Matrix in Attachment "E" shows the report type, stakeholder group and schedule for each communication deliverable. Each report/presentation deliverable is considered available to all distribution levels higher than the level in which it is specified.

Attachment A – Work Breakdown Structure (WBS)

The official WBS for VETSNET is maintained in Primavera IT Project Office and managed by the PM with support from the VBA PMO. The following narrative is representative of the entire WBS contained in TeamPlay.

The full WBS is accessible via the IT Project Office project web site shown in the addenda.

The project web site is updated weekly.

Attachment B – Schedule

The detailed schedule for the VETSNET Project is maintained in Primavera IT Project Office and managed by the PM with support from the VBA PMO. The following narrative is representative of the entire schedule contained in TeamPlay.

The detailed schedule identifies the activities, activity durations, and resources needed (labor and non-labor as required) to complete the VETSNET Project. The schedule tracks the planned start and end dates and the actual start and end date.

The project web site is updated weekly or at the direction of the PM and PCB.

Milestone	Due Date

Attachment C –Risk Assessment Form for Initiative

Initiative Risks:

The process of identifying, allocating, managing and minimizing risk are crucial to the success of the initiative. The ability of the management team to track and understand various risks and then to allocate resources to mitigate them will be a major factor in bringing the initiative in on time and on budget.

Initiative Risks (Use one form for each risk associated with an initiative)

Risk Number:	Date Raised:	Raised By:	Owner:
Short Title:			
Status: <input type="checkbox"/> Draft <input type="checkbox"/> Open <input type="checkbox"/> Rejected <input type="checkbox"/> Closed		Mail Form to Owner: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Evaluation:			
Containment Strategy:			
Probability: <input type="checkbox"/> High (Very Likely) <input type="checkbox"/> Medium (Probable) <input type="checkbox"/> Low (Possible)		Impact: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	

Attachment D – Change Request Form

(Use one form for each Change associated with a baselined project component)

C1. <u>Date Initiated</u>	C2. <u>Initiator</u>
C3. <u>Requested Implementation Date</u>	C4. <u>Change Priority</u>
C5. <u>Change Title</u>	
C6. <u>Change Description:</u>	
C7. <u>Reason for Change:</u>	
C8. <u>Impact of Change (Project work components affected, individuals or groups affected, Cost and Schedule Impact)</u>	
C9. <u>Change Analysis (to be completed by PT)</u>	
C10. <u>Approval/Disapproval</u>	
PCB Member	Date
PCB Member	Date
PCB Member	Date
C11. <u>Date forwarded to ESC</u>	

Attachment E – Communication Matrix

Category	Communication Item	Description	Purpose	Frequency	Media/Tool	Audience	Responsibility (Owner)
Planning	Project Management Plan (PMP)	The PMP documents the management approach and infrastructure required to successfully control the project.	It is a communication tool for the stakeholders to know what will be done and who is responsible for each work effort.	Once but updated as needed.	Word document via email	PT	PMO
Execution	PCB Feedback	PCB shares new information. The PCB Chair emails or calls PT to share information.	Distribute relevant information to PT.	As Needed	Email or Conference Call	PT	PCB Chair
Execution	VEB Feedback	VEB contacts PM with new information. Then PM emails or calls PT to share information.	Distribute relevant information to PT.	As Needed	Email or Conference Call	PM	VEB
Control	Risk Log	Risk ID, creation date, description, person responsible, status, and status date. They will be reviewed in the status meetings and managed using TeamPlay.	Identify and monitor risk events that may impact the project. If they occur, implement corrective action.	Weekly during project meetings	Paper and electronic entry to status system, TeamPlay	PT	PMO
Control	Action Item Log	Action Item ID, creation date, description, person responsible, status, and status date. They will be reviewed in the status meetings.	Issues are concerns that unexpectedly occur during the project and need to be discussed or clarified to resolve. This log will manage that process.	Weekly during project meetings	Paper and electronic entry to status system, TeamPlay	PT	PMO
Control	PT Status Conference Call Agenda	Outline of what will be covered during the Status Conference Call.	Ensure that all areas that need to be discussed are on the agenda. Also, that each person is prepared to discuss the agenda item.	As Needed	Word document distributed via email.	PT	PM
Control	PT Status Conference Calls	Review accomplishments since last meeting, risks/issues, and overall status for the project.	Communicate areas of importance and concern among the PT.	As Needed	Conference call	PT	PM
Control	Project Status Conference Call Minutes	Attendees, agenda, areas/presentations, persons responsible for presentations, action items, next meeting	Informational for records and those who are not in attendance.	Following Conference Call	Word document	PM, PT	PT Member

<u>Category</u>	<u>Communication Item</u>	<u>Description</u>	<u>Purpose</u>	<u>Frequency</u>	<u>Media/Tool</u>	<u>Audience</u>	<u>Responsibility (Owner)</u>
Control	Project Website	The website will contain project information including schedule, risks, reports and documents.	Central repository for all project information.	Updated Weekly by Friday morning.	TeamPlay via HTML.	Everyone	PMO
Control	Master Schedule Report	Report of entire project schedule. Found on the project website.	Reviewed to ensure that there are no issues with the schedule.	Updated Weekly by Friday morning.	Project Website	Everyone	PMO
Control	2 Week Look-ahead report	Snapshot of schedule for the next 2 weeks. Found on the Project Website.	Reviewed during weekly conference call to ensure that there are no issues with the schedule.	Updated Weekly by Friday morning.	Project Website	Everyone	PMO
Control	Ad Hoc Requests	Unique request for assistance from the PT including changes to the project and items needing immediate decisions.	Obtain support for project decisions.	As Needed	Request sent via letter and then discussed via conference call.	Stakeholders	PM
Close-out	Lessons Learned	Brainstorming session that documents what went well and what could be improved regarding this project.	Used as a tool to promote continuous improvement for future project planning.	Once	Word document via email	PT	PM
Control	Risk Log	Risk ID, creation date, description, person responsible, status, and status date. They will be reviewed in the status meetings and managed using TeamPlay.	Identify and monitor risk events that may impact the project. If they occur, implement corrective action.	Weekly during project meetings	Paper and electronic entry to status system, TeamPlay	PT	PMO

Concurrence

Marie S. Causley
Director, VBA Project Management Office

Date

Review

K. Adair Martinez
Deputy Chief Information Officer for Benefits

Date

Review

TBD

Date

Additional Review as required

**Questions for the Record
Honorable Lane Evans
Committee on Veterans' Affairs
February 16, 2005
Hearing on Department of
Veterans Affairs
Fiscal Year 2006 Budget**

Question 9- Attachment

Office of Management and Budget
Exhibit 300 for VETSNET

OMB Exhibit 300 - 2006 (Form) / C&P Benefits Replacement System-2006 (Item)

ProSight

Form Report, printed by: Corrine Cooley, Sep 10, 2004

PART I
Part I: Capital Asset Plan & Business Case (All Assets)
Note: In text fields, the maximum number of characters that can be entered is 4000.

Budget Year

2006

Date of Submission (mm/dd/yyyy)

Sep 13, 2004

Agency

029 - VA

Bureau / Administration

VBA

Network / Station Number	MSN	VSN	VBA AREA

Location in the Budget

Veterans Benefits Administration - Mission Area 4: Comp & Pension

Account Title

VBA Compensation

Account Identification Code

029-25-0134

Program Activity

Mission Area 4: Comp & Pensions

Name of Investment

C&P Benefits Replacement System-2006

Unique Project(Investment) Identifier

(For IT investment only, see section 53. For all other, user agency ID system.) UPI should be created the same for all investments.

029-00-01-13-01-1380-00-101-003

Investment Initiation Date (mm/dd/yyyy)

Sep 1, 1996

Investment Planned Completion Date (mm/dd/yyyy)

Oct 1, 2010

This Investment is:

Full Acquisition

Investment/useful segment is funded:

Fully								
Asset Type								
Information Technology								
Was this investment approved by OMB for previous Year Budget Cycle?								
Yes								
Did the Executive/Investment Review Committee (SMC) approve funding for this investment this year?								
Yes								
Did the CFO (Office of Management - 004) review the cost goal?								
Yes								
Did the Procurement Executive (Office of Management - 004) review the acquisition strategy?								
Yes								
Did the project (investment) manager identified in Section I.D review this Exhibit?								
Yes								
Is this investment included in your agency's annual performance plan or multiple agency annual performance plans?								
Yes								
If this investment supports homeland security, indicate which Homeland Security Mission Area(s) this investment supports (Choose all that apply)								
1) Intelligence & Warning, 2) Border & Transportation Security, 3) Defending Against Catastrophic Threats, 4) Protecting Critical Infrastructure & Key Assets, 5) Emergency Preparedness & Response, 6) Other								
<table border="1"> <thead> <tr> <th>Primary Goal</th> <th>Secondary Goal</th> <th>Tertiary Goal</th> <th>Additional Goal</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Primary Goal	Secondary Goal	Tertiary Goal	Additional Goal				
Primary Goal	Secondary Goal	Tertiary Goal	Additional Goal					
Is this investment information technology? (See section 53 for definition)								
Yes								

Part I: For information technology investments only:
a. Is this project (investment) a Financial Management System? (see section 53.2 for definition)
Yes
If so, does this project (investment) address a FFMIA (Federal Financial Managers Integrity Act) compliance area?
Yes
If yes, which compliance area?
US Standard General Ledger
b. Does this investment implement electronic transactions or record keeping that is covered by the Government Paperwork Elimination Act (GPEA)?
No
If so, is it included in your GPEA plan (and does not yet provide an electronic option)?
Does the investment already provide an electronic option?
No
c. If the investment administers information in identifiable form about members of the public, was a privacy impact assessment submitted via PIA@omb.eop.gov with a unique project (investment) identifier?
Yes

<i>d. Was this investment reviewed as part of the FY 2004 Federal Information Security Management Act review process?</i>
Yes
<i>d.1 If yes, were any weaknesses found?</i>
Yes
<i>d.2 Have the weaknesses been incorporated into the agency's corrective action plans?</i>
Yes
<i>e. Has this investment been identified as a national critical operation or asset by a Project Matrix review or other agency determination?</i>
No
<i>e.1 If no, is this an agency mission critical or essential service, system, operation, or asset (such as those documented in the agency's COOP Plan), other than those identified above as national critical infrastructures?</i>
Yes
<i>f. Was this investment included in a Performance Assessment Rating Tool (PART) Review?</i>
No
<i>f.1 Does this investment address a weakness found during the PART Review?</i>
No
<i>g. Will you use a share-in-savings contract to support this investment?</i>
No
<i>h. Is this investment for construction or retrofit of a federal building or facility?</i>
No
<i>h.1 If yes, are sustainable design practices included in the requirement?</i>
<i>h.2 If yes, is an ESPC being used to fund the requirement?</i>

IA.

IA. Summary of Spending for Project (Investment) Stages

(in millions)

(Estimates for BY+1 and beyond are for planning purposes only and do not represent budget decisions)

FILL IN TABLE IN CURRENT VALUES

Category of Funds	PY-1 and Earlier	PY 2004	CY 2005	BY 2006	BY+1 2007	BY+2 2008	BY+3 2009	BY+4 & Beyond	Total
Planning									
Budgetary Resources	0.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20
Outlays	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Acquisition									
Budgetary Resources	35.12	14.73	7.47	0.00	0.00	0.00	0.00	0.00	57.32
Outlays	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total, Sum of Stages									
Total, Resources (Plan & Acq)	35.32	14.73	7.47	0.00	0.00	0.00	0.00	0.00	57.52
Total, Outlays (Plan & Acq)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Maint									
Budgetary Resources	0.00	0.00	0.00	7.47	7.15	7.16	7.28	7.41	36.47
Outlays	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total, All Stages Resources	35.32	14.73	7.47	7.47	7.15	7.16	7.28	7.41	93.99
Total, All Stages Outlays	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Govt. FTE Costs	5.00	2.73	2.91	2.91	3.06	3.18	3.30	3.43	26.52

*Note: Total, All Stages Resources should equal Total, All Stages Outlays.

Note: Government FTE costs shall include Government personnel considered direct and indirect labor in support of this investment. This includes the investment management IPT and any other Government effort (e.g. programming effort for part of the overall investment, development effort) that contributes to the success of the investment. The costs include the salaries plus the fringe benefit rate of 32.8%. Agencies should reflect estimates of the costs of internal FTE supporting an IT investment, and should at a minimum include in FTE estimates of anyone spending more than 50% of their time supporting this investment. Persons working on more than one investment, whose contributions over all investments would exceed 50% of their overall time, should have their specific time allocated to each investment.

IA. Investment Description

1. Provide a brief description of this investment and its status through your capital planning and investment control (CPIC) or capital programming "control" review for the current cycle.

VBA has been developing and implementing a modernization plan to create an integrated benefits delivery, management information, and decision support system by upgrading and/or replacing outmoded, inflexible technologies and eliminating proprietary system barriers. Also, VBA is pursuing a corporate environment strategy to provide the technology infrastructure for VBA to do business in new ways. This corporate environment provides a set of integrated applications to be shared or reused for common business functions across VBA as well as embedded security functions to monitor access and enforce business processing rules. The effort described above—to establish a comprehensive, nationwide network of benefits delivery—known as the Veterans Service Network (VETSNET). VETSNET Compensation and Pension (C&P) is a streamlined information system that establishes, develops, and rates a claim, prepares award, notifies the veteran, and generates payment information.

VBA's C&P Service proposes to replace its existing award, payment, and accounting system, the Benefits Delivery Network (BDN), with a custom built Compensation and Pension Replacement System (VETSNET C&P). The scope of the investment described here, known as the C&P Replacement System, includes the Award and Finance and Accounting System (FAS) modules. The C&P Benefits Replacement System attempts to address current problems specific to existing C&P benefit processing systems. The C&P Benefits Replacement System development is in progress, having accomplished initial design and development. At the time of this document, VETSNET has completed parallel testing and is currently in live production field test.

The C&P Benefits Replacement System is being developed using the VETSNET integrated architecture. The VETSNET architecture utilizes Graphical User Interface (GUI) screens, an open-system architecture, the corporate database, rating redesign, and claims processing improvements related to compensation and pension functionality.

The corporate environment is targeted to replace the current Benefits Delivery Network (Reference Exhibit 300 - BDN) seeing as BDN has passed its systems life cycle and minimal tools and resources are available to support it. Additionally, various material weaknesses have been identified related to BDN's lack of compliance with the government-wide Standard General Ledger, lack of an automated audit trail, and other shortcomings such as ineffective system messages supporting controls over payment errors. This initiative will also interface with the applications within the C&P Maintenance and Operations Exhibit, which are used to support claims processing, tracking, and employee requirements in support of providing service and benefit payments to veterans.

In March 2002, a C&P Benefits Replacement System concept paper was submitted to the Strategic Management Council and the Deputy Secretary for approval. In December 2002, the C&P Benefits Replacement obtained VA Departmental Milestone 2 System Development Approval in accordance with Departmental guidance. This project was submitted to the CIO and CFO for review and subsequently to the IT Review Board (ITRB). The ITRB provides the final recommendation to the Strategic Management Council for assets/programs to be considered for inclusion into VA's portfolio.

2. What assumptions are made about this investment and why?

The following assumptions were used to describe the present and future environment upon which the C&P Benefits Replacement System development is based.

The C&P Benefits Replacement System will support continuity of interfaces to remaining existing systems such as receivables, deductions, debt collection, Treasury payment scheduling and reporting, and Departmental general ledger maintenance.

The C&P Benefits Replacement System will be capable of being integrated with other IT investment initiatives currently under development in support of C&P claims processing on the corporate environment platform.

The C&P Benefits Replacement System will maintain at least a minimum performance equivalent to current payment processing abilities.

Ongoing operations and maintenance support, as well as functional support (e.g., help desk, Financial Service Center) will remain structurally the same as current operations.

The following constraints were identified for this analysis:

The C&P Benefits Replacement System will integrate with other initiatives supporting end-to-end claims processing.

The C&P Benefits Replacement System will be constrained in generating payment schedule outputs by Treasury's ability to accept and generate hard-copy checks (i.e., to veterans who are unable to receive electronic funds transfers).

The proposed investment is mindful of ongoing efforts at the Departmental level, such as the movement to a central veteran repository. The C&P Benefits Replacement System represents the completion of the veteran C&P payment process and is the remaining components to be deployed. Establishing the claim, tracking the claim, and determining disability all support the final award and payment of the claim to the veteran. Without the installation of these final components, timely and accurate future payments could become more difficult and harder to achieve.

3. Provide any other supporting information derived from research, interviews, and other documentation.

Over the last few years, VBA leadership has analyzed the challenges of the current BDN system and identified business and technical drivers for change. Business drivers for change include: 1) the need to capitalize on the opportunity to support an efficient and effective award and payment of benefits to the veteran, 2) the fact the current system does not support the strategic direction of C&P, VBA, and VA, as well as 3) the fact limited human resources are available to adequately maintain the legacy system for the next three years.

The BDN system's award and payment processing requires several routine, manual or semi-manual that could be automated. Currently, rating data must be re-keyed into BDN, retroactive amounts must be calculated manually, and awards are generated cyclically. This lack of automation and redundant data entry may lead to decreased data accuracy.

VA's strategic direction is moving towards a veteran centric business model. In support of this change, VA's vision includes becoming a more veteran-focused organization, functioning as a comprehensive provider of seamless service to men and women who have served our nation. Additionally, VA strives to cultivate a dedicated workforce of highly skilled employees who understand, believe in, and take pride in our vitally important mission. VBA and C&P have incorporated this understanding into their vision and core values to promote a shift within the organization. Requiring significant business and technology model changes, legacy systems such as BDN do not readily fit into the vision of this shifting focus.

Like most government agencies, VBA is facing large number staffs that are eligible for retirement in the near future. This is particularly significant for VBA Office of Information Management Staff (OIM) staff with nearly 56% of the entire workforce eligible for retirement in the next 2 years. Such a turnover may cause significant problems in maintaining legacy systems using outdated technologies (such as BDN). OIM has developed a succession plan and has established priorities projects to build and maintain the capacity of VBA's IT resources to meet the needs of the field stations, five program services, and VBA stakeholders. One of these priorities includes the C&P Replacement System.

Several technical drivers for change have been identified and further support moving to a modernized environment, they are listed below:

- Although the hardware of the BDN system was recently upgraded, no architectural changes in the application software were made.
- The legacy system consists of multiple accounting systems, requires multiple data entries, and the establishment and maintenance of multiple records.
- The BDN is still primarily a batch application, with little automation in the management and control of batch jobs, and an antiquated back-end for the management of correspondence and mailing.
- The legacy system uses proprietary software and equipment with a limited life.

Consequently, several major weaknesses persist. These weaknesses are:

- BDN lacks adequate controls to prevent RO personnel from manipulating data to reflect better claims processing timeliness than actually achieved.
- A lack of adequate control and lack of historical transaction data prevents management officials from identifying and correcting erroneous entries into the automated system.
- The BDN system is unable to implement procedures allowing it to collect, analyze, and use information on the specific causes of overpayments. For instance, the current system is unable to monitor the quality and consistency of adjustment actions.
- BDN does not have effective audit trails. Thus, the visibility of specific batch processes of BDN transactions is not clear and the impact of BDN processes on transactions cannot be fully determined. This makes it very difficult, if not impossible, to identify and correct error conditions.

IB.**IB. Justification (All Assets)**

In order for IT investments to successfully address support of the President's Management Agenda and justification of the investment, the investment should be collaborative and include industry, multiple agencies, State, local, or tribal governments, use e-business technologies and be governed by citizen needs. If the investment is a steady state investment, then an E-Gov strategy review is underway and includes all the necessary elements. If appropriate, this investment is fully aligned with one or more of the President's E-Gov initiatives.

Which of your agency's strategic goals & objectives does this project support? (Select all that apply)

Primary Goal	Secondary Goal	Tertiary Goal	Additional Goal	Additional Goal
Quality of Life	One VA			

1. How does this investment support your agency's mission and strategic goals and objectives?

The primary mission of the Department of Veterans Affairs is to "honor, compensate, and care for veterans in recognition of their sacrifice for America." One of the most direct ways in which the Department achieves this mission is through the award and payment of benefits to veterans in the form of compensation and pension (C&P) benefits. The investment proposed in this document is for a system providing automated support to the award, payment, and associated accounting functions for VBA's C&P program. VBA provides 42 million payments to approximately 3.1 million veterans and their dependents annually. Furthermore, this initiative closes the circle of redesign efforts for the end-to-end C&P claims processing cycle: from initial claim application through review, rating, and adjudication to the award and FAS process...

In addition to the clear and direct support that this investment provides in serving a significant number of veterans, the C&P Replacement System will also assist VBA and C&P in performing required recording and monitoring functions to support financial management at both the Administration and Departmental levels. The proposed system will accept the results of the claims adjudication process, calculate and support timely approval of award amounts; generate required payment transactions through Treasury for timely issuance of payment checks and electronic funds transfers, generate the associated audit trail for those payment transactions, and provide automated support for reconciliation, reporting, payment inquiries, and other critical information management functions.

This investment is necessary to replace the current C&P Benefits Delivery Network (BDN) functionality that does not support compliance with federal financial management regulations, does not provide automated support for adequate control over payment processing, and does not support critical customer service needs such as immediate response to payment inquiries and immediate feedback regarding processing errors to allow timely corrections and processing of appropriate payment amounts. The existing system has as its foundation an outdated and complex command driven platform, with negative implications for long-term system life-cycle support (only user of proprietary software and equipment). Furthermore, over the next 3 years VBA's Office of Information Management (OIM) will face a shortage of personnel who are qualified to maintain the legacy system since over half of its personnel are eligible for retirement. Finally, the proposed investment in information technology support for these functions will bring benefits processing for C&P into alignment with broader strategic objectives and information technology standards of the Department and will support wider access to and use of information associated with the processing of C&P payments.

If applicable, what laws & regulations must the project address?

Which Presidential Management Agenda items does this project support? (Select all that apply)

Primary Goal	Secondary Goal	Tertiary Goal	Additional Goal	Additional Goal
Improved Fin. Performance	Expanded E-Gov.			

2. How does it support the strategic goals from the President's Management Agenda?

This initiative supports the goal of Improved Financial Performance through more timely financial information and

compliance with JFMIP requirements. The C&P Replacement System will support online processing of financial and accounting transactions, reducing the number of batch processes. This new system will provide better control of payment processing and was designed to be compliant with federal financial management requirements. Therefore, there will be a reduction = internal data interfaces. This system will have daily interfaces with VA's financial management system and provide VA's staff with current financial information. In addition, this system will have audit functionality through the introduction of transaction level audit trails and expanded data access and controls. These added control features would allow VBA to edit data more thoroughly and trace individual transaction and user entries to ensure against errors and data manipulation.

The C&P Replacement System also supports the President's Expanded Electronic Government initiative through improved access to veteran information. VBA employees will be able to provide more timely and accurate information to veterans. The information in the system will have online processing and VBA employees will be accessing the latest veteran information. Also, VBA employees will be able to locate information more quickly with enhancements to the search capabilities. More information will be available including a record of event dates, award effective dates, family member ratings, clothing allowance and burial award decisions, as well as service connected death ratings.

Though this system is not being developed through interagency collaboration, VBA will be able to share information online more easily with other stakeholders, both internal and external to the Department. VHA employees will have access to text descriptions of disabilities and other eligibility data without having to contact VBA to verify veteran eligibility. Veteran Service Organizations (VSOs) will be given access to the system (in accordance with security requirements) and will be able to view descriptions of all decisions by decision dates and rating date.

3. Are there any alternative sources in the public or private sectors that could perform this function?

No

4. If so, explain why your agency did not select one of these alternatives.

As part of a detailed cost benefit analysis of alternatives for the proposed investment, VBA evaluated the feasibility of outsourcing the functions to be performed by the recommended system. Several obstacles were identified that prevented VBA from taking advantage of any potential benefits associated with use of an alternative source as the provider for the requisite functions.

First, the nature of the functions to be performed is mixed, i.e., programmatic and financial or administrative. The award function is programmatic in nature, whereas the payment and accounting functions are more administrative.

Outsourcing or cross-servicing of the award, payment, and accounting functions was analyzed as part of the detailed cost benefit analysis for this investment; the analysis evaluated aspects of outsourcing each sub-process as well. The first sub-process is award, which is, as stated above, programmatic in nature. It brings to closure the entire claims processing cycle and primarily involves final review and approval of award decisions and payments to be made. The very nature of this sub-process makes it inappropriate for outsourcing, i.e., decision-making and impacting use of federal funding. Furthermore, it would be awkward to abstract solely the award process from the earlier phases of claims processing as would be required for cross-servicing, and would present significant obstacles related to sharing of data and systems across agencies with little foreseen benefit (i.e., few FTE involved but much data sharing and understanding of programmatic details and basis for approval required).

The remaining sub-processes were also considered, even though the award sub-process was determined to be inappropriate for outsourcing or cross servicing. The payment process as it is currently performed and as it would be envisioned within the proposed alternative is almost entirely automated. Based on the information entered during the award phase, the payment is calculated using sophisticated, internal models, and a limited string of data is output to Treasury to initiate the payment process. There are essentially no user processes to outsource from a functional perspective. From a technical perspective, the proposed investment is planned to eliminate the need for much of the currently manual or semi-automated payment batch scheduling and associated support functions. The goal is to simplify the IT environment. The C&P Replacement System implements a single accounting system whereas the legacy system consists of multiple accounting systems.

Finally, the proposed investment will support accounting functions related to payment processing, and management of information captured within the system. The proposed investment once again is planned to eliminate any significant manual or semi-automated processes required, leaving only core federal financial management functions such as certification of funds availability, reconciliation, and standard reporting. None of these functions is appropriate for outsourcing to a non-federal entity, nor do they require such a level of FTE as would create cost-efficiencies through cross servicing. The effort required to share systems, data, and related forms and procedures would outweigh any possible benefits to be gained by the few functions that might be cross-serviced. Thus, outsourcing/cross-servicing was determined not to be a feasible option for VBA for C&P award, payment, and accounting.

5. Who are the customers for this investment?

Veterans (~3.1 Million), all C&P Employees (5,600), Veteran Service Organizations (2,250 read only access) VA Financial

Staff (29), and Veterans Health Administration (VHA) (Approximately 9,000 users located at 180 medical centers), Internal Revenue Service (IRS), Bureau of Prisons (BOP), Department of Treasury, and National Cemetery Administration (NCA).

6. Who are the stakeholders of this investment?

All the above customers plus other VBA business lines that base their benefits on C&P disability ratings such as Vocational Rehabilitation and Employment (VR&E) Service and Education Service.

7. If this is a multi-agency initiative, identify the agencies and organizations affected by this initiative (Select all that apply).

Agency 1	Agency 2	Agency 3	Agency 4

7a. If this is a multi-agency initiative, discuss the partnering strategies you are implementing with the participating agencies and organizations.

Not Applicable.

8. How will this investment reduce costs or improve efficiencies?

The investment proposed in this application supports the critical process of awarding and making payments for disability compensation and pensions to veterans. This process is reasonably straightforward in nature. The intent of this investment therefore, is to: 1) correct current deficiencies in the process and 2) increase automation of the process and thereby improve data integrity, process controls, accuracy and timeliness of payments, and facilitation of associated financial management functions.

This investment will achieve these goals and improve efficiencies in the following ways:

- Increases automation and allow greater integration of Award and FAS processes with pre-award processes.
- Enhances the timeliness of awards and payments through real-time processing.
- Increases the access of information to VBA employees who respond to veteran requests thereby increasing veterans' confidence in the accuracy and effectiveness of the C&P program.
- Permits streamlined data processing, less searching through file folders, and better audit control measures through online processing.
- Eliminates reentry of data throughout the claims process.
- Required data entry fields are more intuitive, legacy system required users to enter cryptic codes and memorize screen numbers.
- Makes available to the user by subject area all past decisions.
- Corrects areas of non-compliance by providing a standard general ledger (SGL) compliant system, audit trails at the user and transaction levels, and thorough documentation.
- Provides online reconciliation support (e.g., research payment transaction history online, generate reconciliation reports).
- Increases data integrity and flexibility of the systems, thereby expanding its use for management analysis and reporting purposes that currently would need to be performed manually or not at all.
- Provides increased access to data to support an expanded user base within VBA, without requiring extensive manual data collection on the part of VA staff to support such requests.
- Provides immediate response to data entry and processing so that users can correct errors and complete processing of transactions more timely.
- Provides more user-friendly access to and use of the system for all users.
- Aligns technical capabilities with other VBA information technology initiatives, VBA technical standards, and industry

standards, thereby facilitating future integration and upgrades.

Cost savings will be achieved through cost avoidance and systems savings. The current BDN system does not provide Regional Offices (ROs) with access to information necessary to review and reconcile batches of transactions processed by Hines on their behalf. In addition, Hines maintains the printing and mailing functions and system processes to distribute letters to veterans, and copies of those letters and other reports to the ROs. Because errors in processing could result in delayed payments or inaccurate financial status or could prevent RO staff from knowing the status of veteran payment, these mailings are done via overnight express. This investment will eliminate the C&P-related portion of this cost. Since only a negligible portion of the cost is estimated to be attributable to non-C&P processes, the entire annual cost is reflected as a cost avoidance from the legacy system. Therefore, a reduction in postage presents one of the areas of cost avoidance for this investment. The estimated annual cost for the C&P mailing service is \$134,000 (constant year 2002).

9. List all other assets that interface with this asset.

The C&P Benefits Replacement System has been developed based on a standardized business process. Therefore, any assets having been reengineered were done so in accordance of the business process, rather than the C&P Benefits Replacement System. The C&P Benefits Replacement System interfaces with the VA's Financial Management System.

Have these assets been reengineered as part of this investment?

No

IC. - ID.

IC. Performance Goals & Measures

In order to successfully address this area of the business case, performance goals must be provided for the agency and be linked to the annual performance plan. The investment must discuss the agency's mission and strategic goals, and performance measures must be provided. These goals need to map to the gap in the agency's strategic goals and objectives that this investment is designed to fill. They are the internal and external performance benefits this investment is expected to deliver to the agency (e.g., improve efficiency by 60%, increase citizen participation by 300% a year to achieve an overall citizen participation rate of 75% by FY 2xxx, etc.). The goals must be clearly measurable investment outcomes, and if applicable, investment outputs. They do not include the completion date of the module or investment, or general goals, such as, significant, better, improved that do not have a quantitative or qualitative measure.

For Existing IT projects that have previously submitted Exhibit 300s:

--> If you completed Table 1 last year, please use Table 1 to report for fiscal years 2003 and 2004 and Table 2 for fiscal years 2005 through at least 2007.

--> If you completed only Table 2 last year, please use Table 2 to report for fiscal years 2005 through at least 2007.

For projects that are submitting Exhibit 300s for the first time:

--> Use Table 2.

--> Report on Performance Measures for at least two years, i.e., FY 2006 and 2007, FY 2007 and 2008.

--> If the project will have data for 2005 that you wish to include, add extra lines in Table 2 and complete all information in this single table.

--> At least one performance goal must be met by BY+1.

Table 1

	Fiscal Year	Strategic Goal(s) Supported	Existing Baseline	Planned Performance Improvement Goal	Actual Performance Improvement Results	Planned Performance Metric	Actual Performance Metric Results
1	2003	Quality of Life	181 Days	Improve average days to process rating related actions	Meet Improvement Goal	179 Days	179 Days
2	2003	Quality of Life	56%	Improve Overall Customer Satisfaction	Meet Improvement Goal	58%	58%
3	2003	Quality of Life	186 Days	Decrease Average Days pending for rating related actions	Meet Improvement Goal	185 Days	185 Days
4	2003	Quality of Life	55 Days	Non rating actions average days to process	Meet Improvement Goal	53 Days	53 Days
5	2003	Quality of Life	117 Days	Non-rating actions average days to pending	Meet Improvement Goal	113 Days	113 Days
6	2003	Quality of Life	62%	National Accuracy rating (authorization work)	Meet Improvement Goal	63%	63%
7	2003	Quality of Life	68%	National accuracy rating (fiduciary work)	Meet Improvement Goal	69%	69%
8	2004	Quality of Life	181 Days	Improve average days to process rating related		176 Days	

				actions			
9	2004	Quality of Life	56%	Improve Overall Customer Satisfaction		61%	
10	2004	Quality of Life	186 Days	Decrease Average Days pending for rating related actions		183 Days	
11	2004	Quality of Life	55 Days	Non rating actions average days to process		52 Days	
12	2004	Quality of Life	117 Days	Non-rating actions average days to pending		111 Days	
13	2004	Quality of Life	62%	National Accuracy rating (authorization work)		64%	
14	2004	Quality of Life	68%	National accuracy rating (fiduciary work)		69.5%	
15							
16							
17							
18							

Table 2

Fiscal Year	Measurement Area	Measurement Category	Measurement Indicator	Baseline	Planned Improvements to the Baseline	Actual Results
2005	Customer Results	Customer Benefit	Customer Satisfaction	181 Days	Improve average days to process rating related actions to 179 days	
2005	Mission and Business Results	Information and Data	Information Management	186 Days	Decrease Average Days pending for rating related actions to 181 Days	
2005	Processes and Activities	Productivity and Efficiency	Productivity	68%	National accuracy rating (fiduciary work) - 70%	
2005	Technology	Effectiveness	User Satisfaction	56%	Improve Overall Customer Satisfaction to 63%	
2006	Customer Results	Customer Benefit	Customer Satisfaction	179 days	Improve average days to process rating related actions to 175 days	
2006	Mission and Business Results	Information and Data	Information Management	181 Days	Decrease Average Days pending for rating related actions to 179 Days	

2006	Processes and Activities	Productivity and Efficiency	Productivity	70%	National accuracy rating (fiduciary work) - 72%	
2006	Technology	Effectiveness	User Satisfaction	63%	Improve Overall Customer Satisfaction to 66%	
2007	Customer Results	Customer Benefit	Customer Satisfaction	175 days	Improve average days to process rating related actions to 173 days	
2007	Mission and Business Results	Information and Data	Information Management	179 Days	Decrease Average Days pending for rating related actions to 176 Days	
2007	Processes and Activities	Productivity and Efficiency	Productivity	72%	National accuracy rating (fiduciary work) - 74%	
2007	Technology	Effectiveness	User Satisfaction	66%	Improve Overall Customer Satisfaction to 70%	
2008	Customer Results	Customer Benefit	Customer Satisfaction	173 days	Improve average days to process rating related actions to 170 days	
2008	Mission and Business Results	Information and Data	Information Management	176 Days	Decrease Average Days pending for rating related actions to 170 Days	
2008	Processes and Activities	Productivity and Efficiency	Productivity	74%	National accuracy rating (fiduciary work) - 76%	
2008	Technology	Effectiveness	User Satisfaction	70%	Improve Overall Customer Satisfaction to 74%	

ID. Program Management (Investment Management)

1. Is there a project manager assigned to the investment?

Yes

1. A Identify the members, roles, qualifications, and contact information of the in-house and contract project (investment) managers for this project (investment).

	Project Manager Names	Project Manager Role/Qualifications	PM Phone	PM Fax	Email
Primary in-house	Thompson, Dianne	The C&P Benefits Replacement System project is managed by the Office of Information Management's Program Management Organization (PMO). It was established to manage the performance and capability of the collection of assets organized to implement this project. The PMO is led by a Program Manager. The Program Manager designated for this exhibit has over 15 years of project	202-273-6865		imrdthom@vba.va.gov

		management experience and is certified Level III Program Manager, as of December 2003. The PMO has adopted an Integrated Project Team (IPT) approach to program management. The PMO is supported by the following: business users, field users, procurement, technical resources, as well as Software-Capability Maturity Model (SW-CMM) level 4 contractor professionals who support the day-to-day management of the Pother certification level noted is consistent with CIO Council guidance.			
Alternate in-house	Meyer, Bret	A Level III VA Project Manager with a Masters Certificate from George Washington University in Project Management, he has provided project management support in the analysis, design and development of the entire suite of VETSNET applications over the past 8 years. In addition, he has completed the five day Contracting Officer's Representative course from Management Concepts. As Chief of the Systems Development Division at the St. Petersburg Systems Development Center (SPSDC), he will serve as the Task Oriented Project Manager of the NGIT contract there. This contract's primary focus is the Awards and Payment systems - the heart of the C&P Benefits Replacement System. In this capacity he will be monitoring the projects current expenses ensuring they are in line with the business requirements and helping to forecast future budget requirements.	727-319-5943		vetbmeye@vba.va.gov
Contractor					

2. Is there a contracting officer assigned to the project (investment)?

Yes

If so, what is his/her name?

Contract Officer Name	Contract Officer Phone / Fax / Email
Chris Burroughs	202-273-6984 / chris.burroughs@mail.va.gov

3. Is there an Integrated Project Team?

Yes

3. A If so, list the skill set represented.

A Project Charter was developed to provide the authority for delivery of the project. The Charter identifies and defines three management structures, in addition to the project team, to ensure change requests and issues affecting project completion are properly controlled. The Project Control Board (PCB) consists of a Project Manager and supporting functional team leaders. The Executive Board (EB) furnishes executive direction to the PCB. The Information Technology Investment Board (ITIB) provides oversight for the project.

The Project Manager is responsible for all project functions and operates within the project management system, integrates all the capabilities and resources of the project team and heads the project's organizational structure. In addition, the Project Control Board tracks and reports on project status, initiate corrective action, and manages the development, budget, execution, control and closure of the plan.

The project delivery and functional teams are responsible for developing the strategies to deliver the project, documenting project plan elements, developing detailed schedules, and developing resource estimates.

The Executive Board (EB) provides oversight and guidance, approves policies, plans, standards and procedures, approves changes in the scope of the project, oversees cross-organization participation, budget, and monitors and progress and performance.

The Office of Field Operations determines the level of involvement by their office. They are responsible for assessing the impact to field personnel and workload, advising the Project Manager on union/employee concerns and issues, and assuring that implementation concerns are identified and addressed.

The Project Management Division is available for assisting project teams in developing and maintaining the detailed project schedules, quantifying resource estimates to complete project delivery, and maintaining a database of all VBA project initiatives.

The Configuration Manager is responsible for the development of the project Configuration Management Plan and the execution of baseline identification, change control, status reporting, and reviews throughout the life of the Project.

Represented skills sets include: Project Management; Information Security Expertise; Financial Management; Acquisition Procedures; Budget Procedures; Application Development; Operational Expertise; Business Line Subject Matter Expertise; Field Operations Subject Matter Expertise; Data Management.

4. Is there a sponsor/owner for this investment?

Yes

4. A If so, identify the sponsor/process owner by name and title and provide contact information.

Sponsor/Owner Name & Title	Sponsor/Owner Phone / Fax / E-mail
Ruth Whichard/ Compensation and Pension Service	202-273-7265 / caprwhic@vba.va.gov

IE.

IE. Alternatives Analysis

In order to successfully address this area of the business case, you must include three viable alternatives that were compared consistently, identify the alternative chosen, and provide benefits and reasons for your choice. Agency must identify all viable alternatives and then select and report details on the top three viable alternatives. Use OMB Circular A-94 for all investments and the Clinger Cohen Act for IT investments for the criteria to be used for Benefit/Cost Analysis. Agency must include the minimum criteria to be applied in considering whether to undertake a particular investment, including criteria related to the quantitatively expressed projected net, risk adjusted return on investment, and specific quantitative and qualitative criteria for comparing and prioritizing alternative investments.

For IT investments, agencies should use the Federal Enterprise Architecture (FEA) to identify potential alternatives for partnering or joint solutions that may be used to close the identified performance gap.

1. Describe the alternative solutions you considered for accomplishing the agency strategic goals that this project was expected to address. Describe the results of the feasibility/performance/benefits analysis. Provide comparisons of the returns (financial and other) for each alternative.

General data assumptions served as the foundation for a cost element structure that is consistently applied throughout the cost benefit analysis. These assumptions provide a basis for capturing cost for the status Quo (SQ)-Baseline and all viable alternatives. In line with the requirements of the VA Capital Investment process and the Office of Management and Budget (OMB), the following components were considered as "blocks" for building possible IT solutions:

- Build: Developing custom software designed to support C&P's specific award, payment, and accounting requirements.
- COTS: Installing a vendor-developed, commercial off-the-shelf (COTS) products.
- Outsourcing: Selecting procuring support from an outside entity (either public or private) in performing required award, payment, and accounting functions or processes.

In addition to considering these as separate and distinct alternatives, it is often desirable to combine multiple components to create a hybrid, thereby obtaining benefits of each component where applicable.

Based on the concepts described above, five potential alternatives were identified and determined to reasonably address the strategic, functional, and technical needs of this project

1. A Discuss the market research that was done to identify innovative solutions for this project (e.g., used an RFI to obtain four different solutions to evaluate, held open meetings with contractors to discuss project scope, etc.). Also describe what data was used to make estimates: past or current contract prices for similar work, contractor provided estimates from RFIs or meetings, general market publications, etc.

	Alternative Name	Description
Alternative 1	Status Quo - Baseline	The status quo involves maintaining the systems, processes, and staff in the current environment. The award, payment, and accounting functions for C&P are currently performed using the Benefits Delivery Network (BDN). The BDN comprises multiple hardware and software platforms, and a communication infrastructure that supports critical VBA functions. It also enables distribution of over 42 million payments each year to 3.1 million veterans. The term 'BDN' refers to hardware and software platforms, and communication infrastructure is essential to support the functions of the C&P service.
Alternative 2	Custom Build	This alternative involves completing the software development of the Award and FAS modules of C&P Replacement System.
Alternative 3	Upgrade BDN	The Upgraded BDN alternative involves significant redesign of the award, payment and accounting modules of the C&P application.
Alternative 4	Hybrid: Custom Build/COTS	The Custom Build/COTS alternative involves completing the Award components of the C&P Replacement System and acquiring a COTS software product to replace the payment and accounting functionality. In addition, development of a middleware application will be required to interface the hybrid system with existing internal and external interfaces. This factor may require extensive analysis and design to the integration phase of the project.

2. Summarize the results of your life-cycle cost analysis performed for each investment (USE DISCOUNTED DOLLARS)

1	Element	Alternative 1	Alternative 2	Alternative 3	Alternative 4
		Status Quo - Baseline	Custom Build	Upgrade BDN	Hybrid: Custom Build/COTS
1	System Investment	0.000	27.678	18.507	24.947
2	System Operations and Maintenance	77.748	28.453	73.332	32.730
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13	Alternative Total	77.748	56.132	91.838	57.677

Summarize the underlying assumptions you made when completing your analysis:

Alternative cost comparisons was derived from a combination of interviews, existing documents, standard methodologies, and judgment. The methodological assumptions applied to the viable alternatives are the following: Sunk costs (costs already incurred) are not included in this analysis. Costs are projected based upon a ten-year investment/operating period. Vendor proposal data is used where appropriate. Costs are estimated in constant year dollars, base year 2002. The constant year dollars were inflated by 2.0% and then the OMB A-94 nominal discount rate of 5.1% was applied to each alternative to calculate the present value dollars. The C&P Replacement System will support continuity of interfaces to remaining existing systems such as loan receivables, insurance deductions, debt collection, Treasury payment scheduling and reporting, and Departmental general ledger maintenance. The C&P Replacement System will be capable of being integrated with other IT investment initiatives currently under development in support of C&P claims processing on the corporate environment platform. The C&P Replacement System will maintain at least a minimum performance equivalent to current payment processing abilities. Ongoing operations and maintenance support, as well as functional support (e.g., help desk, Financial Service Center) will remain structurally the same as current operations.

3. Which alternative was chosen and why?

The three alternatives analyzed provide differing approaches for satisfying C&P Replacement System requirements. A CBA was conducted in support of this submission and incorporated costs, benefits, and risks of each alternative under consideration. Based on results, both the custom build and hybrid alternatives provide a higher financial return, greater benefits, and lower risks when compared against the status quo environment. The Custom Build is the preferred over the Hybrid; the Custom Build alternative provides the lowest cost, aligns to VA's strategic direction and has the lowest risk, given these factors the Custom Build is the recommended solution for implementation.

3.A Are there any quantitative benefits that will be achieved through this investment (e.g., systems savings, cost avoidance, stakeholder benefits, etc)?

Yes. Implementation of a new system for C&P will present opportunities for cost savings and cost avoidance. It is assumed that the selected alternative will provide greater effectiveness and efficiency; therefore, C&P may reduce cost on resource expenditures. C&P may reduce or avoid costs in the following areas: System Savings and Postage Costs Avoidance. The system savings represent the difference between the costs to maintain the status quo and the costs to maintain each viable alternative. For the C&P Replacement System, these system savings will be realized in terms of personnel time to support the Award and FAS environment. These FTEs can use the 25% efficiency time-savings to perform other mission related functions. These FTEs are the technical personnel at the Hines and Austin Automation Centers who perform various systems operation and maintenance functions specifically pertaining to C&P payment and accounting processing. The weighted average grade level of technical personnel for those organizations is GS 9. For software maintenance, the division is separated into two sections, on-line and batch. These C&P systems personnel are responsible for maintenance of core applications, maintenance of 184 interfaces, and new development on an as-needed basis. Workload is primarily a function of work requests received from VACO, production support, and support given to the field. Based on previous studies for VA systems and studies of similar sized projects, it is estimated that there is a 25% efficiency gain for this area. The current BDN system does not provide Regional Offices (ROs) with access to information necessary to review and reconcile batches of transactions processed by Hines on their behalf. In addition, Hines maintains the printing and mailing functions and system processes to distribute letters to veterans and copies of those letters and other reports to the ROs. Because errors in processing could result in delayed payments or inaccurate financial status or could prevent RO staff from knowing the status of veteran payment, these mailings are done via overnight express. The estimated annual cost for the C&P mailing service is \$134,000 (constant year 2002). Any of the alternatives to the baseline can alleviate the current need for express mailing to the ROs based on the introduction of real-time processing capabilities. Thus, it is assumed that implementation of any of the alternatives will eliminate the C&P-related portion of this cost. Since only a negligible portion of the cost is estimated to be attributable to non-C&P processes, the entire annual cost is reflected as a cost avoidance from SQ-Baseline. Therefore, a reduction in postage presents one of the areas of cost avoidance for this investment. This cost avoidance will be realized the year the new system is fully operational. For the Custom Build alternative this will begin in September of 2002, for the remaining viable alternatives this will begin in FY 2005. Thus the total ten year postage costs avoidance is greater for the Custom Build alternative than it is for the other two alternatives.

Define the Return on Investment (ROI)

3

3.B For the alternative selected, provide Net Present Value by Year (5, 10, 15 or 30 years, depending on project life cycle).

NPV by Year

Year		2006	2007	2008	2009	2010	2011	2012
Enter NPVs:		4.46	3.99	3.87	3.87	3.64	3.54	3.53
Year	2013	2014	2015	2016	2017	2018	2019	2020
Enter NPVs:								
Year	2021	2022	2023	2024	2025	2026	2027	2028
Enter NPVs:								
Year	2029	2030	2031	2032	2033	2034	2035	

Enter NPVs:								

Enter the year that Payback occurs:

2005

4. What is the date of your cost benefit analysis? (mm/dd/yyyy)

Aug 1, 2002

IF. -IG.

1 IF. Risk Inventory & Assessment

In order to successfully address this issue on the business case and capital asset plan, you must have performed a risk assessment at the initial concept, included mandatory risk elements defined below and demonstrate active management of the risk throughout the life-cycle of the investment.

For all investments, both IT and non-IT, you must discuss each of the following risks and present your plans to eliminate, mitigate, or manage risk, with milestones and completion dates. If there is no risk to the investment achieving its goals from a risk category, indicate so. If there are other risks identified, include them. Risk assessments should include risk information from all stakeholders and should be performed at the initial concept stage and then monitored and controlled throughout the life-cycle of the investment. Risk assessments for all investments must include: 1) schedule; 2) initial costs; 3) life-cycle costs; 4) technical obsolescence; 5) feasibility; 6) reliability of systems; 7) dependencies and interoperability between this investment and others; 8) surely (asset protection) considerations; 9) risk of creating a monopoly for future procurements; 10) capability of agency to manage the investment; and 11) overall risk of investment failure.

In addition, for IT investments, risk must be discussed in the following categories 12) organizational and change management; 13) business; 14) data/info; 15) technology; 16) strategic; 17) security; 18) privacy; and 19) project resources. For security risks, identify under the Description column the level of risk as high, medium, or basic. What aspect of security determines the level of risk, i.e., the need for confidentiality of information, availability of information or the system, reliability of the information or system? Under the Current Status column, list the milestones remaining to mitigate the risk.

	Date Identified	Risk Category	Description	Probability of Occurrence	Strategy for Mitigation	Current Status as of the Date of this Exhibit
1	Jun 1, 2003	Schedule	Changes to VBA standards and infrastructure may require additional effort	High	Detailed project schedules and resources analyses are conducted to identify and track critical path and dependencies. The project team will coordinate with other VBA technology projects that will have an impact on delivery schedule (Sun migration, Windows 2000, etc.) ensure schedules are reconciled and resource estimates incorporated into schedule. Different contract types can be explored to encourage more proposals from contractors.	Business Sponsors and OIM consistently review business requirements and analyze the strategy to ensure timely delivery and reasonable expectations.
2	Jun 1, 2003	Initial Costs	Cost overruns due to evolving requirements	Basic	Develop, establish, and implement change control board and change management procedures. Monitor plan versus actual budget by contract deliverable.	VETNSET cost baselined: Dec. 31 2002; planned versus actual cost updates provided to PMO by Project Managers at the 15th of each month
3	Jun 1, 2003	Life-Cycle Costs	Cost overruns due to evolving requirements	Basic	Develop, establish, and implement change control board and change management procedures. Monitor plan versus actual budget by contract deliverable.	VETNSET cost baselined: Dec. 31 2002; planned versus actual cost updates provided to PMO by Project Managers at the 15th of each

						month
4	Jun 1, 2003	Technical Obsolescence	System will not support business processes	Medium	Consistent business process help to reach uniformity will mitigate this risk. Rigorous testing will minimize "surprises" come deployment. The project team will maintain, update, and adhere to the development methodology and standard development process that has been implemented. The VA's Technical Resource Model and Standards Profile (TRM) provide a baseline of standards that is used throughout the VA organization. Compliance with these standards ensures that the system provides an interface that is consistent with other VBA systems, VA systems, and other external systems.	VBA is developing a Succession Plan for OIM personnel. VBA is reviewing the possibility of supplementing current personnel with contractor support as well as retention bonuses for current staff to assist in maintaining a knowledge base.
5	Jun 1, 2003	Feasibility	Effort does not support an enterprise approach to application development	Basic	The system is based on the corporate data model developed during the Requirements Analysis phase. This model contains entities, attributes, and relationships that span the entire scope of VBA operations. The design of this model allows for a flexible system that can adapt to VBA's requirements and maintain interoperability among the various systems. The development methodology used relies heavily on the interaction and input of the business/functional experts and the user community, thereby ensuring that user expectation and needs will be met by the completed application.	User testing and training are integrated into the overall project management plan.
6	Jun 1, 2003	Reliability of Systems	System will not function as specified or suffer shortfall(s) in performance.	Basic	VBA plans to perform benchmark modeling and simulation studies.	Load testing to be conducted before National Rollout - Testing contractor support procured for the effort.
7	Jun 1,	Dependencies	Effort does not	Basic	The system is based on	Dependencies and

		2003 & Interoperability Btw. this Investment & Others	support an enterprise approach to claims processing		the business model developed during the Requirements Analysis phase. This model contains relationships that span the entire scope of related VBA applications. Similarly to the technical aspect of the data model, the design of this model allows for a flexible system that can adapt to VBA's requirements and maintain interoperability among the various systems. The development methodology used relies heavily on the interaction and input of the business/functional experts and the user community, thereby ensuring that user expectation and needs will be met by the completed application.	relationships between C&P Benefits Replacement and other VBA applications are integrated into the overall project management plan.
8	Jun 1, 2003	Surety (Asset Protection) Considerations	Lack of change controls for monitoring of security flaws and attention to C&A processes	Medium	A security plan and schedule are developed to ensure that risk assessments and certification and accreditation are conducted in a timely manner and prior to production.	VBA is securing funding to provide certification and accreditation support to all system owners to update and/or develop the required documentation, and to conduct certification activities.
9	Jun 1, 2003	Risk of Creating a Monopoly for Future Procurements	The Government will become dependent on one contractor for completing the project	Medium	Requirements defined by business lines that, in connection with guidelines from FFMSR and through the JFMIP, continue to track the adherence of compliance.	Tracking deliverables by Task Order Project Manager.
10	Jun 1, 2003	Capability of Agency to Manage the Investment	Loss of key functional expertise may affect management effectiveness	Basic	Departmental reorganization efforts may shift program responsibility more towards OIM than the business lines; likewise, there are efforts to restructure the St. Petersburg System Development Center (SPSDC).	Reorganization efforts have been implemented with minimal disruption to service.
11	Jun 1, 2003	Overall Risk of Project Failure	Applications will not support VA Departmental objectives	Basic	Develop requirements and validate development based on VA/VBA Strategic and Tactical Plans. Obtain all	Received System Development Approval (Milestone II)

					Departmental requirements in relation to the Milestone approval process	
12	Jun 1, 2003	Organizational & Change Management	Project will lose management support	Basic	This is a top priority of the Undersecretary for Benefits. VBA has established an Executive board that meets regularly to discuss to all MAP components including the Compensation and Pension Replacement System.	Weekly Project Control Board Meetings; Monthly Executive Board Meetings; Weekly Status Update sent to Undersecretary for Benefits
13	Jun 1, 2003	Business	System will not be accepted by users	Medium	Develop Change Management and marketing strategy to 'sell' C&P replacement applications and processes. Develop a system based on the standardized, corporate data model. This model contains entities, attributes, and relationships agreed to by both IT and business representation. Incorporate a flexible application design, allowing for adaptability to VBA's requirements and interoperability.	User testing and training are integrated into the overall project management plan.
14	Jun 1, 2003	Data/Info.	Increased number of data sources including internal databases and external verification activities	High	Develop applications in accordance with Departmental Enterprise Architecture standards and procedures. Follow a consistent software development methodology.	Monitoring and synchronizing legacy and current environment
15	Jun 1, 2003	Technology	VBA lacks experience with the technology being used	Medium	Consistent business process help to reach uniformity will mitigate this risk. Rigorous testing will minimize "surprises" come deployment. The project team will maintain, update, and adhere to the development methodology and standard development process that has been implemented. The VA's Technical Resource Model and Standards Profile (TRM) provide a baseline of standards that is used throughout the VA organization. Compliance	VBA is developing a Succession Plan for OIM personnel. VBA is reviewing the possibility of supplementing current personnel with contractor support as well as retention bonuses for current staff to assist in maintaining a knowledge base.

					with these standards ensures that the system provides an interface that is consistent with other VBA systems, VA systems, and other external systems.	
16	Jun 1, 2003	Strategic	Inadequate risk assessments	Basic	The system is based on a corporate data model developed during the requirements analysis phase. This model contains entities, attributes, and relationships that span the entire scope of VBA operations.	The design of this model allows for a flexible system that can adapt to VBA's requirements and maintain interoperability among various systems.
17	Jun 1, 2003	Security	Disclosure of private data	Basic	A security plan and schedule are developed to ensure that risk assessments and certification and accreditation are conducted in a timely manner and prior to production.	VBA is securing funding to provide certification and accreditation support to all system owners to update and/or develop the required documentation, and to conduct certification activities.
18	Jun 1, 2003	Privacy	Difficulty securing contractors and limited contracting expertise in Task Order Managers	Medium	Solicit contractor support early in development lifecycle. Establish business relationships VA Departmental Security Office in order to leverage existing successful contract efforts.	Defined as a requirement
19	Jun 1, 2003	Project Resources	Underestimate level of effort due to evolving requirements	Medium	The project management is employing Earned Value Management. A cost benefit analysis was completed has been conducted with a 10 year lifecycle and a sensitivity analysis which show potential cost impacts of changes in cost assumptions. If the scope threatens to expand or additional implementation actions are identified that were not included in the initial plan, the Executive Steering Committee and Project Control Board will take appropriate action to allow or deny these actions and will exercise their authority to obtain additional resources as needed.	Fixed price contracts are being used when feasible. This project has a VBA Program Analyst assigned to monitor and track the budget and expenses.

1. What is the date of your risk management plan? (mm/dd/yyyy)

Jun 1, 2003

2 IG: Acquisition Strategy

In order to adequately address this area of the business case and capital asset plan you must employ a strong acquisition strategy that mitigates risk to the Federal Government, accommodate Section 508 as needed, and use performance based contracts and statements of work (SOWs). If you are not using performance based fixed price contracts, your acquisition strategy should clearly define the risks that prompted the use of other than performance based contracts and SOWs. Finally, your implementation of the Acquisition Strategy must be clearly defined.

1. Will you use a single contract or several contracts to accomplish this project?

several

1.A What is the type of contract/task order if a single contract is used?

1.B If multiple contract/task orders will be used, discuss the type, how they relate to each other to reach the project outcomes, and how much each contributes to the achievement of the project cost, schedule and performance goals.

Different contractors will be used in three different areas: Project management, development, and test and software quality assurance. The project manager (PM) is responsible for integrating all performance-based contracts into a consistent organization of integrated and dependent work breakdown structure (WBS). This consolidated WBS will be the basis for the planned cost, schedule, and performance baseline. The PM is also responsible for ensuring each contract-specific Work Breakdown Structure accounts for all deliverables as identified in the respective Statement of Work (SOW).. As actual work is accomplished and on a regular basis, the integrated project team evaluates overall project performance to determine if quality standards are being met as well as verify if the baseline performance (identified during the planning phase) differs from actual performance.

Also discuss the contract/task order solicitation or contract provisions that allow the contractor to provide innovative, transformational solutions.

2. For other than firm-fixed price, performance-based contracts, define the risk not sufficiently mitigated in the risk mitigation plan, for that contract/task order, that require the Government to assume the risk of contract achievement of cost, schedule and performance goals. Explain the amount of risk the government will assume.

The project management contract will be Fixed Price. The Development is currently time and materials but is moving to fixed price. The Test contract is cost plus fixed fee.

It was determined by the C&P Benefits Replacement staff that due to the concurrent events of project requirements, design, builds, test, and deployment, certain time and material contracts would be allowed. The existing risk resulting in this decision was the fluidity of business and technical requirements. As of October 2002, all business requirements have been revalidated by VBA. The amount of risk the government will assume is less than the reward the VBA will gain by having the margin to build an application that will truly support the Veteran's needs.

3. Will you use financial incentives to motivate contractor performance (e.g. incentive fee, award fee, etc.)?

No

4. Discuss the competition process used for each contract/task order, including the use of RFP's, schedules or other multiple agency contracts, etc.

Normal competitive bid processes were used to obtain contract support. There were at a minimum, 3 competitors selected to provide services on this contractor.

5. Will you use commercially available or COTS products for this investment?

Yes

5.A To what extent will these items be modified to meet the unique requirements of this project?

COTS products will only be used to help build the system.

5.B What prevented the use of COTS without modification?

Due to the unique nature of Veteran Benefits, research indicated any sole COTS product solution would require significant tailoring to me business requirements.

6. What is the date of your acquisition plan? (mm/dd/yyyy)

Oct 1, 2003

7. How will you ensure Section 508 compliance?

The IT Architecture and Engineering Service, located within the Deputy Chief Information Office for Benefits, is responsible for identifying applicable technical provisions, conducting research to identify adaptive products, drafting specifications, and documenting non-availability and undue burden determinations. The VBA Architectural Change Review Board assists in monitoring, evaluating, and ensuring compliance with Section 508.

In addition, contracting officials are expected to pursue effective acquisition strategies for acquiring technology services and products. The section 508 standards are incorporated, and made part of all VA contracts, solicitations, and purchase orders. Contractors are provided with a copy of the standards and must comply with the referenced standards. The Contracting Officer's Technical Representative is responsible for ensuring the contractors adhere to the reference standards.

VA has an Adaptive Training Program, which provides PC-based adaptive equipment training, consultations and technical support to veterans and government employees with disabilities. An Individual Learning Center is located at VA Central Office.

The VA Section 508 portal provides a central location for project managers to learn more about Section 508 requirements, the Architectural and Transportation Barriers Compliance Board (ACCESS) standard requirements, current activities, future developments, and contact information for those individuals seeking information and assistance regarding Section 508.

The VA CIO Council established a Department wide Section 508 Advisory Committee, composed of representatives across VA.

8. For the budget year, what percentage of the total investment is for hardware, software and services?

(After entering percentages for hardware, software and services, click the "Submit" button at the upper right of the Form to calculate the % Total field. % Total must equal 100.)

% Hardware	% Software	% Services	Total %
0.00	2.00	98.00	100.00

IH1.- IH3.**IH. Project (Investment) and Funding Plan**

In order to successfully address this section of the business case, you must demonstrate use of an Earned Value Management System (EVMS) that meets ANSI/EIA Standard 748, for both Government and contractor costs, for those parts of the total investment that require development efforts (e.g., prototypes and testing in the planning phase and development efforts in the acquisition phase) and show how close the investment is to meeting the approved cost, schedule and performance goals. Information on EVMS is available at www.acq.osd.mil/pm.

For those investments in the operations/steady state phase, you must perform an operational analysis as defined in the Capital Programming Guide to demonstrate how close the investment is to achieving the expected cost, schedule and performance goals for this phase.

Program status information in this section must include both the contractor's part of the investments overall costs and milestone requirements as well as the Government's costs and milestone requirements to successfully complete the investment phase, segment or module being reported.

IH.1 Description of Performance-based Management System (PBMS)

Explain the methodology used by the agency to analyze and use the earned value performance data to manage performance. Describe the process you will use or used to verify that the contractor's project management system follows the ANSI/EIA Standard 748-A. If the investment is operational (steady state), define the operational analysis system that will be used. If this is a mixed life-cycle investment with both operational and development/modernization/enhancement (DME) system improvement aspects, EVMS must be used on the system improvement aspects of the investment and operational analysis on the operations aspects.

Using information consistent with the work breakdown structure (WBS), provide the information requested in all parts of this section.

Explain the methodology used to analyze and use the earned value performance data to manage performance. Describe the process you will use or used to verify that the contractor's project management system follows the ANSI/EIA Standard 748-A. If this is a mixed life-cycle investment, EVMS must be used on the system improvement aspects of the investment.

VBA is currently implementing the Primavera TeamPlay product suite as the standard performance based management system. C&P Benefits Replacement System project managers have completed training and have begun transitioning to TeamPlay as the project management system. The data within this tool will be validated in 2005 when fully implemented.

This enterprise project management (EPM) software tool provides industry standard earned value performance metrics satisfying the criteria for ANSI/EIA-748-1998, Earned Value Management Systems. Primavera TeamPlay enables VBA to increase overall project return on investment and contain costs by aligning project management strategies with business goals and capital budget plans.

This enterprise project, process, and resource management software tool will provide overall visibility into priorities, progress, and staffing. Project managers can quickly analyze the impact of changing resource limits, activity priorities and constraints on the overall project goals. This will allow VBA to make informed decisions and provide the capability to deliver projects on time and within budget through the capture and reuse of best practices.

The Software Development and Program Management contractor support contracts are required to be compliant with Carnegie Mellon University's Software Capability Maturity Model (SW-CMM) Level 4 standards and procedures. Certification letters for the above contracts are on file.

If the investment is operational (steady state), define the operational analysis system that will be used. If this is a mixed life-cycle investment, operational analysis must be used on the operations aspects of the investment.

IH.2 Original Baseline (OMB approved at investment outset)

What are the cost and schedule goals for this phase or segment/module of the investment (e.g., what are the major investment milestones or events; when will each occur; and what is the estimated cost to accomplish each one)? Also identify the funding agency for each milestone or event if this is a multi-agency investment. For operational or steady state projects, complete one line on the chart for each year of this phase. If the project is mixed lifecycle there will be two parts to the chart; one for the O&M portion and one for the developmental portion using EVMS. If this is a multi-agency investment or one of the President's E-Gov initiatives, use the detailed investment plan with milestones on the critical path, to identify agency funding for each module or milestone. (This baseline must be included in all subsequent reports, even when there are OMB-approved baseline changes shown in I.H.3).

**Cost and Schedule Goals: Original Baseline for a Phase/Segment/Module of Project (Investment)*

Original baseline Phase/Segment/Module of Project (Investment)?

Full Project Schedule

	Description of Milestone	Schedule Start Date	Schedule End Date	Schedule Duration (Days)	Planned Cost	Funding Agency
1	Government Project Management	Oct 1, 2002	Sep 30, 2004	700	1,096,700.00	VBA
2	Contractor Project Management	Oct 1, 2002	Sep 30, 2004	700	1,616,000.00	VBA
3	Government Software Development	Oct 1, 2002	Sep 30, 2004	700	6,398,578.00	VBA
4	Contractor Software Development	Oct 1, 2002	Sep 30, 2004	700	11,047,200.00	VBA
5	Government Training Development	Oct 1, 2002	Sep 30, 2004	700	66,119.00	VBA
6	Government Training Delivery	Oct 1, 2002	Sep 30, 2004	700	7,392,525.00	VBA
7	Government Training Travel	Oct 1, 2002	Sep 30, 2004	700	354,411.00	VBA
8	Contractor Training Development	Oct 1, 2002	Sep 30, 2004	700	141,231.00	VBA
9	Security	Oct 1, 2002	Sep 30, 2004	700	707,236.00	VBA
10	Production Deployment	Apr 16, 2004	Jan 13, 2005	405	7,470,000.00	VBA
11	Maintenance-2006	Jan 16, 2005	Sep 30, 2005	285	5,580,000.00	VBA
12	Maintenance-2007 through 2009	Oct 1, 2006	Sep 30, 2009	1,095	15,510,000.00	VBA
13	Prior Year Planning and Development	Sep 1, 1996	Sep 30, 2002	2,190	31,520,000.00	VBA
14	Program Testing	Oct 1, 2002	Sep 30, 2004	700	5,000,000.00	VBA
15						

Completion Date:	Oct 1, 2009	Total Cost Estimate at Completion:	79,900,000.00
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IH.3 Proposed Baseline / Current Baseline (Applicable only if OMB-approved the changes):

Identify in this section a proposed change to the original or current baseline or an OMB-approved baseline change. What are the new cost and schedule goals for the phase or segment/module (e.g., what are the major investment milestones or events; when will each occur; and what is the estimated cost to accomplish each one)? Also identify the funding agency for each milestone or event if this is a multi-agency investment. If this is a new investment in the 2006 Budget year, this section will be blank for your initial submission.

*Cost & Schedule Goals: Baseline for a Phase / Segment / Module of Project (Investment)

Proposed or Current Baseline?

Proposed

Proposed or current baseline Phase/Segment/Module of Project (Investment)?

Full Project Schedule

	Description of Milestone	Schedule Start Date	Schedule End Date	Schedule Duration	Planned Cost	Funding Agency
1	Government Project Management	Oct 1, 2002	Sep 30, 2004	700	1,096,700.00	VBA
2	Contractor Project Management	Oct 1, 2002	Sep 30, 2004	700	1,616,000.00	VBA
3	Government Software Development	Oct 1, 2002	Sep 30, 2004	700	6,398,578.00	VBA
4	Contractor Software Development	Oct 1, 2002	Sep 30, 2004	700	11,047,200.00	VBA
5	Government Training Development	Oct 1, 2002	Sep 30, 2004	700	66,119.00	VBA
6	Government Training Delivery	Oct 1, 2002	Sep 30, 2004	700	7,392,525.00	VBA
7	Government Training Travel	Oct 1, 2002	Sep 30, 2004	700	354,411.00	VBA
8	Contractor Training Development	Oct 1, 2002	Sep 30, 2004	700	141,231.00	VBA
9	Security	Oct 1, 2002	Sep 30, 2004	700	707,236.00	VBA
10	Production Deployment	Apr 16, 2004	Jan 13, 2005	405	2,790,000.00	VBA
11	Maintenance - 2006	Jan 16, 2005	Sep 30, 2005	285	3,850,000.00	VBA
12	Maintenance - 2007 through 2010	Oct 1, 2006	Sep 30, 2010	1,460	27,856,000.00	VBA
13	Prior Year Planning and Development	Sep 1, 1996	Sep 30, 2002	2,190	31,520,000.00	VBA
14	Program Testing	Oct 1, 2002	Sep 30, 2006	840	5,500,000.00	VBA
15						

Completion date:	Sep 30, 2010	Total cost estimate at completion:	94,000,000.00
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IH4.

IH.4 Actual Performance and Variance from OMB-approved Baseline (original or current)

A. This section is always filled in to reflect current status of the investment. It compares the OMB approved baseline and actual results for this phase, segment, or module of the investment. Show for each major investment milestones or events you planned (scheduled) to accomplish and the cost and what work was actually done and the cost. If the project is in the operational or steady state phase complete one line on the chart for each year. For these projects complete paragraphs C, D, F and G as appropriate. If this is a new investment in the 2005 Budget year, this will be blank for your initial submission. OMB may ask for latest information during the budget review process.

*Comparison of OMB-Approved Baseline and Actual Outcome for Phase/Segment/Module of a Project (Investment)

Actual Performance Phase/Segment/Module of Project (Investment)?

Full Project Schedule

	Description of Milestone	OMB Start Date	OMB End Date	OMB Duration (days)	OMB Planned Cost	OMB Funding Agency	Actual Start Date	Actual End Date	Actual Percent Complete	Actual Cost
1	Government Project Management	Oct 1, 2002	Sep 30, 2004	700	1,096,700.00	VBA	Oct 1, 2002		85.00	932,195.00
2	Contractor Project Management	Oct 1, 2002	Sep 30, 2004	700	1,616,000.00	VBA	Oct 1, 2002		85.00	1,373,600.00
3	Government Software Development	Oct 1, 2002	Sep 30, 2004	700	6,398,578.00	VBA	Oct 1, 2002		85.00	5,438,785.00
4	Contractor Software Development	Oct 1, 2002	Sep 30, 2004	700	11,047,200.00	VBA	Oct 1, 2002		85.00	9,390,120.00
5	Government Training Development	Oct 1, 2002	Sep 30, 2004	700	66,119.00	VBA	Oct 1, 2002		85.00	56,201.00
6	Government Training Delivery	Oct 1, 2002	Sep 30, 2004	700	7,392,525.00	VBA	Oct 1, 2002		85.00	6,283,646.00
7	Government Training Travel	Oct 1, 2002	Sep 30, 2004	700	354,411.00	VBA	Oct 1, 2002		85.00	301,249.00
8	Contractor Training Development	Oct 1, 2002	Sep 30, 2004	700	141,231.00	VBA	Oct 1, 2002		85.00	120,046.00
9	Security	Oct 1, 2002	Sep 30, 2004	700	707,236.00	VBA	Oct 1, 2002		85.00	601,150.00
10	Production Deployment	Apr 16, 2004	Jan 13, 2005	405	7,470,000.00	VBA	May 10, 2004		5.00	373,500.00
11	Maintenance-2006	Jan 16, 2005	Sep 30, 2005	285	5,580,000.00	VBA			0.00	0.00
12	Maintenance-2007 through	Oct 1, 2006	Sep 30, 2009	1,095	15,510,000.00	VBA			0.00	0.00

	2009									
13	Prior Year Planning and Development	Sep 1, 1996	Sep 30, 2002	2,190	31,520,000.00	VBA	Sep 1, 1996	Sep 30, 2002	100.00	31,520,000.00
14	Program Testing	Oct 1, 2002	Sep 30, 2004	700	5,000,000.00	VBA	Oct 1, 2002		60.00	4,250,000.00
15										

Completion Date: OMB Approved Baseline:	Oct 1, 2009	Estimated Completion Date:	Sep 30, 2009
Total Cost: OMB Approved Baseline:	79,900,000.00	Estimate at Completion:	94,000,000.00

B. Provide the following investment summary information from your EVMS data:

EVMS As of Date:	Aug 31, 2004
B.1 Show the budgeted (planned) cost of work scheduled (BCWS \$):	60,640,492.00
B.2 Show the budgeted (planned) cost of work performed (BCWP \$):	59,390,500.00
B.3 Show the actual cost of work performed (ACWP \$):	60,640,492.00

B.4 Provide a cost curve graph plotting BCWS, BCWP and ACWP on a monthly basis from inception of this phase or segment/module through the latest report.

In addition, plot the ACWP curve to the estimated cost at completion (EAC) value and provide the following EVMS variance analysis.

Project (Investment) Summary (Cumulative)	Value
Cost Variance = (BCWP-ACWP) =	-1,249,992.00
Cost Variance % = (CV/BCWP) x 100% =	-2.10
Cost Performance Index (CPI) = (BCWP/ACWP) =	0.98
Schedule Variance = (BCWP-BCWS) =	-1.25
Schedule Variance % = (SV/BCWS) x 100% =	-2.06
Schedule Performance Index (SPI) = (BCWP/BCWS) =	0.98
First independent Estimate at Completion (EAC) = ACWPCum = (Performance Factor (PF) x (BAC-BCWPCum) where PF = 1/CPI =	74,342,432.00
Second independent Estimate at Completion (EAC) = ACWPCum = (Performance Factor (PF) x (BAC-BCWPCum) where PF = 1/(CPI x SPI) =	74,630,817.00
Variance at Completion (VAC) = (BAC minus EAC) for first EAC above =	-1,532,432.00
Variance at Completion (VAC) = (BAC minus EAC) for second EAC above =	-1,820,817.00
Variance at Completion % = (VAC/BAC) x 100% for first EAC above =	-2.10

Variance at Completion % = $(VAC/BAC) \times 100\%$ for second EAC above =	-2.10
Estimated Cost to Complete (ETC) =	13,419,500.00
Expected Completion Date =	Sep 30, 2010

Definitions for Earned Value Management System

ACWP - Actual Cost for Work Performed - What you paid.

BAC - Budget at Completion - The baseline (planned) budget for the project.

BCWP - Budgeted Cost for Work Performed - The earned value.

BCWS - Budgeted Cost for Work Scheduled - The planned costs.

CPI - Cost Performance Index - The ratio of the budgeted to actual cost of work performed.

CV - Cost Variance - The difference between planned and actual cost of work performed.

EAC - Estimate at Completion - The latest estimated cost at completion.

ETC - Estimate to Completion - Funds needed to complete the investment.

PF - Performance Factor - The cost to earn a dollar of value, or $ACWP/BCWP$, or $1/CPI$.

SPI - Schedule Performance Index - The percent of the investment that has been completed.

SV - Schedule Variance - The variance between the actual and planned schedules.

VAC - Variance at Completion - The variance between the baseline and actual budget at completion.

C. If cost and/or schedule variance are a negative 10 percent or more at the time of this report or EAC is projected to be 10 percent more, explain the reason(s) for the variance(s).

Not Applicable.

D. Provide performance variance. Explain, based on work accomplished to date, whether or not you still expect to achieve your performance goals. If not, explain the reasons for the variance. For steady state projects, in addition to a discussion on whether or not the system is meeting the program objectives, discuss whether the needs of the owners and users are still being met.

Based on work accomplished to date, this project is expected to achieve its performance goals.

E. For investments using EVMS, discuss the contractor, government, and at least the two EAC index formulas in I.H.4.B, current estimates at completion. Explain the differences and the IPT's selected EAC for budgeting purposes. This paragraph is not applicable to operations/steady state projects.

F. Discuss the corrective actions that will be taken to correct the variances, the risk associated with the actions, and how close the planned actions will bring the investment to the original baseline.

Define proposed baseline changes, if necessary.

The C&P Benefits Replacement System project has been revalidated to include additional beta testing at the Lincoln Regional Offices. Consequently, the project was restructured to reflect funding realities and to address VBA's priority to migrate off the legacy BDN system as soon as possible.

G. If the investment cost, schedule or performance variance is 10 percent or greater, has the agency head concurred in the need to continue the program at the new baseline?

Yes

PART II (IT ONLY)

Part II: Additional Business Case Criteria for Information Technology

II.A Enterprise Architecture

In order to successfully address this area of the business case and capital asset plan you must ensure that the investment is included in the agency's EA and CPIC process, and is mapped to and supports the Federal Enterprise Architecture. You must also ensure that the business case demonstrates the relationship between the investment and the business, data, application, and technology layers of the EA.

II.A.1 Business

A. Is this investment identified in your agency's enterprise architecture?

Yes

If not, why not?

Not Applicable.

A.1 Will this investment be consistent with your agency's "to be" modernization blueprint?

Yes

B. Was this investment approved through the EA Review committee at your agency?

Yes

C. What are the major process simplification/reengineering/design projects that are required as part of this investment?

There were two process simplification/reengineering/design projects underway within VBA that contributed to the C&P Replacement System initiative. The Claims Process Improvement (CPI) established claims processing teams within the defined claims processing functions of Triage, Pre-Determination, Rating, Post-Determination, Appeals and Public Contact. This was implemented at four pilot test stations (Milwaukee, Reno, Roanoke and San Diego). Additional Triage Units in VBA Regional Offices were established to assign work to the appropriate function team or work the case in the triage unit if the issue can be quickly resolved (one-time actions). The Pension consolidation initiative consolidated all existing pension programs into three pension centers. Consolidation into these pension centers began with two paper-based environments and one imaged environment. Migration to a fully paperless environment for all sites is planned over the next two years.

D. What are the major organization restructuring, training, and change management projects that are required?

This investment includes developing and delivering user training for three modules: Award Compensation, Award Pension, and FAS. The delivery method used will be train the trainer and the training will be given in four phases:

- Phase 1 - Overview Course
- Phase 2 - Train the Trainer/Award Compensation
- Phase 3 - Train the Trainer/Award Pension
- Phase 4 - Train the Trainer/FAS

There will be an overview course that will last five days and will be completed at the Baltimore Regional Office. At the training session, the representatives will be trained in Award Compensation, Award Pension, and/or FAS. One representative from each of the 58 ROs will attend. These representatives will, in turn, return to their respective RO and train the staff located there. The number of users to be trained of each module varies as follows:

- Award Compensation has 3019 users to be trained
- Award Pension has 250 users to be trained
- FAS has 400 users to be trained
- There are about 100 casual users to be trained

Each of the three modules will have a will have a 5-day training session, which will be conducted at each RO with Award Compensation and Pension having multiple sessions. Training has been conducted at the Lincoln Regional Office, which is the beta site for the deployment.

E. Please list the primary Line of Business and Sub-Function that this IT investment supports. Refer to the www.feapmo.gov site "FY 06 A-11 FEA Additional Instructions and Guidance and Reference Model Changes v 1 (Draft)" for the revised BRM listings. The primary BRM mapping for this initiative also should have been identified with the last six digits of the unique project (investment) identifier in section 53.8. In addition to listing the primary LOB/functions and mode of delivery, you may list up to, but not more than, three (3) non-primary

LOB/function/sub function. Include mode of delivery entries for any non-primary "Service to Citizens" entries.

	Line Of Business / Sub-function	Line of Business Code	Sub- Function Code	Mode of Delivery	Mode of Delivery Code	Mode of Delivery Sub function Code
1	Community & Social Svcs/Social Svcs	101	003	Direct Service to the Citizen/Civilian Operations	201	068
2	Litigation&Judicial Activities/Judicial Hearing	116	051	Direct Service to the Citizen/Civilian Operations	201	068
3	Litigation&Judicial Activities/Resolutn Facilitatn	116	055	Direct Service to the Citizen/Civilian Operations	201	068
4	Financial Mgmt/Reporting and Information	402	129	Direct Service to the Citizen/Civilian Operations	201	068
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II.A.2 Data

A. What types of data will be used in this investment? Examples of data types are health data, geospatial data, natural resource data, etc.

Data used in this project includes:

- Veteran Personal data: Name, Address, Social Security Number, Family/Dependents, Marital Status, Medical Status, Birth Information, Death Information
- Service Data: Reserve and Guard Participation, retired pay or severance pay, hazardous agent exposure, Branch of service, duty date, released date, type of discharge, separation reason
- Medical Records: Military clinical records, government health records, vocational rehabilitation and employment records, line of duty investigations
- Police Records: Incarceration at federal state or local facility, fugitive felon status, investigative reports for some accident
- Guardian Information: Court proceedings, field examinations, appointment and bonding of fiduciaries, annual accountings
- Veteran Dependent Data: Personal information including name and address, age, school status, relationship to the veteran, medical status
- Account History: case/account number, identity of beneficiary, eligibility determination information, benefit information, payment history
- Disability Compensation: Case/Account Number, identity of beneficiary, contact history, eligibility determination information, benefit entitlement information, payment history
- Non Service Connected Pension: Case/Account Number, identity of beneficiary, contact history, eligibility determination information, benefit entitlement information, payment history

B. Does the data needed for this investment already exist at the Federal, State, or local level? If so, what are your plans to gain access to that data?

Yes. Data internal to VBA will be accessed through the WAN/LAN environment. Data external to VBA will be exchanged securely over the Internet through the extranet firewall and in accordance with VA security policy.

C. Are there legal reasons why this data cannot be transferred? If so, what are they and did you address them (legal reasons) in the barriers and risk sections above?

No, the data may be transferred, but confidential business information, Privacy Act and information is subject to confidentiality protections.

D. If this initiative processes spatial data, identify planned investments for spatial data and demonstrate how the agency ensures compliance with the Federal Geographic Data Committee standards required by OMB Circular A-16.

Not applicable. This initiative does not process spatial data.

E. If this activity involves the acquisition, handling or storage of information that will be disseminated to the public or used to support information that will be disseminated to the public, explain how it will comply with your agency's Information Quality guidelines (section 51.5 requirements)

C&P Benefits Replacement is fully compliant with VA's System of Record policy and procedures.

F. Managing business information means maintaining its authenticity, reliability, integrity, and usability and providing for its appropriate disposition. Address how the system will manage the business information (records) that it will contain throughout the information life cycle

The information processed is sensitive data because it contains personal information associated with veterans of all the armed services and their family members. This information includes names, social security numbers, and dates of birth, marriage, and death as well as information describing the financial status of veterans. VBA has emplaced strict control measures to prevent the inadvertent or deliberate release of information to non-authorized personnel. Security programs and procedures have been developed to ensure: (1) the protection of veterans, beneficiary, and employee data; (2) the privacy of personal data; (3) the prevention of system operation disruptions; and (4) the elimination of negligent and/or fraudulent misuse of VBA information resources. The protection requirements for this application's data have been reviewed and identified according to relative importance of protection needs for the system, based upon the degree of security needed for the data being processed in terms of confidentiality, integrity, availability, and accuracy.

II.A.3 Applications, Components & Technology

A. Discuss this major investment in relationship to the Service Component Reference Model. Include a discussion of the components in

this major IT investment (e.g., Knowledge Management, Content Management, Customer Relationship Management, etc.). Refer to the www.feapmo.gov site "FY 06 A-11 FEA Additional Instructions and Guidance and Reference Model Changes v 1 (Draft)" for the revised SRM listings and instructions.

See table below.

Use the table provided below to discuss IT investments in relation to the SRM.

Note: If your Service Component is a new component (Not on the OMB defined list of Service component as listed on the drop down for "Component" column in SRM Table below) then, select "Yes" for "New Component?" (Yes or No) column, update the "Relation to SRM (i.e. Component Description)" column with your new component name and description, and select "No Value" for "Component" column in the SRM Table below.

	Relation to SRM (i.e. Component Description)	Service Domain	Service Type	Component	New Component? (Yes or No)
1	Interactive Voice Recognition	Customer Services	Customer Relationship Management	Call Center Management	No
2	Tracking & Workflow	Customer Services	Customer Initiated Assistance	Case / Issue Management	No
3	Customer inquiries	Customer Services	Customer Initiated Assistance	Self-Service	No
4	Case Management	Customer Services	Customer Initiated Assistance	Process Tracking	No
5	Automated and manual case management	Process Automation Services	Routing and Scheduling	Inbound Correspondence Management	No
6	Automated authorization process	Process Automation Services	Routing and Scheduling	Outbound Correspondence Management	No
7	Structured data	Digital Asset Services	Document Management	Library / Storage	No
8	Ad hoc retrieval	Digital Asset Services	Knowledge Management	Information Retrieval	No
9	Standard reporting	Business Analytical Services	Reporting	Standardized / Canned	No
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B. Are all of the hardware, applications, components and web technology requirements for this investments included in the Agency EA Technical Reference Model? If not, please explain.

Yes. All of the C&P Replacement System hardware, applications, and infrastructure are included in the EA TRM

C. Discuss this major IT investment in relationship to the Technical Reference Model. Identify each or multiple Service Area(s), Service Category(ies), and Service Standard(s) that collectively describe(s) the technology supporting each component identified in the SRM Mappings in II.A.3.A "Component" column above.(Note: The values in "Relation to "SRM" (Component)" column in the TRM Table II.A.3.C below and the values in "Component" column in SRM Table II.A.3.A above should be the same, except where the component is new, then the value should match the "Relation to SRM(i.e. Component Description)" column in SRM Table II.A.3.A above). Refer to the www.feapmo.gov site "FY 06 A-11 FEA Additional Instructions and Guidance and Reference Model Changes v 1 (Draft)" for the revised TRM instructions.

See table below.

Use the table provided below to define IT investment TRM categories in relation to the SRM.

Refer to the "FY 06 A-11 FEA Additional Instructions and Guidance v 1 (Draft)" for detailed guidance on component and technical standard entries and mappings.

	Relation to "SRM" (Component)	Service Area	Service Category	Service Standard
1	Call Center Management	Service Access and Delivery	Access Channels	Collaboration Communications
2	Case/Issue Management	Service Access and Delivery	Access Channels	Collaboration Communications
3	Process Tracing	Component Framework	Data Management	Reporting and Analysis
4	Self-Service	Service Access and Delivery	Delivery Channels	Internet
5	Self-Service	Service Access and Delivery	Delivery Channels	Intranet
6	Inbound Correspondence Management	Component Framework	Data Management	Reporting and Analysis
7	Outbound Correspondence Management	Component Framework	Data Management	Reporting and Analysis
8	Library/Storage	Service Platform and Infrastructure	Database / Storage	Database
9	Information Retrieval	Component Framework	Data Management	Reporting and Analysis
10	Standardization/Canined	Component Framework	Data Management	Reporting and Analysis
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D. Will the application leverage existing components and/or applications across the Government (i.e., FirstGov, Pay Gov, etc.)?

No

If so, please describe.

Not Applicable.

E. Financial Management Systems and Projects, as indicated in Part I, must be mapped to the agency's financial management system inventory provided annually to OMB. Please identify the system name(s) and system acronym(s) as reported in the most recent systems inventory update required by Circular A-11 Section 52.4.

Not Applicable.

II.B. Security & Privacy

In order to successfully address this area of the business case, each question below must be answered at the investment (system/application) level, not at a program or agency level. Simply referring to security plans or other documents is not an acceptable response.

For IT investments under development, security planning must proceed in parallel with the development of the system to ensure that IT security requirements and costs for the lifecycle of the investment are identified and validated. All IT investments must have up-to-date security plans and be fully certified and accredited prior to becoming operational. Anything short of a full certification and accreditation indicates that identified IT security weaknesses remain and need to be remedied and is therefore not adequate to ensure funding for the investment.

Additionally, to ensure that requests for increased IT security funding are appropriately addressed and prioritized, the agency must identify: 1) current costs; 2) current IT security performance gaps; and 3) how the funding request will close the performance gaps. This information must be provided to OMB through the agencies' plan of action and milestone developed for the system and tied to the IT business case through the unique project (investment) identifier.

In addition, agencies must demonstrate that they have fully considered privacy in the context of this investment. Agencies must comply with Section 208 of the E-Government Act and forthcoming OMB implementing guidance and, in appropriate circumstances, conduct a privacy impact assessment that evaluates the privacy risks, alternatives and protective measures implemented at each stage of the information life cycle. Agencies should utilize the guidance provided in OMB Memoranda in conducting the PIA and submit a copy, using the unique project (investment) identifier, to OMB at PIA@omb.eop.gov.

II.B.1 How is security provided and funded for this project (e.g., by program office or by the CIO through the general support system/network)?

IT security is addressed both at the enterprise and project levels, with funding for both efforts being provided by individual program offices. At the Department level, the CIO's Office of Cyber and Information Security (OCIS) establishes directives, policies, and procedures which are consistent with the provisions of the Federal Information Security Management Act (FISMA) and other related federal laws, as well as guidance issued by the Office of Management and Budget (OMB) and the National Institute of Standards and Technology (NIST). This guidance is contained in VA Directive 6210, Automated Information Systems Security, which is currently being updated, and will be reissued later this calendar year. Overarching mission strategies of this directive, as well as a structured framework for effective implementation of programmatic goals, are articulated in the VA IT Security Program Management Plan, which is updated quarterly.

At the project level, a standardized Department methodology is used to continually monitor and evaluate security for this effort. In accordance with the provisions of FISMA, a self-assessment of IT security management, operational, personnel, and technical controls is conducted on an annual basis, modeled after NIST Special Publication 800-26, Self-Assessment Guide for Information Technology Systems. The survey, which encompasses information concerning over 200 controls in 17 discrete categories, is completed by team(s) of information security officers, technical leads, and facility CIO. The survey was last completed in August, 2003.

The results of the survey are used in the annual IT Security Review, which is conducted immediately following the close of the survey period. During this review, the VA CIO, in conjunction with program managers and VA component CIO, and with advice from the VA Office of Inspector General (OIG), evaluates the Department's overall IT security posture. The results of the review include identification of significant security performance gaps, and prioritization of key weakness areas for immediate remediation action, thereby effectively targeting those areas that will most improve the Department's security posture in the near-term.

Progress in remediating identified deficiencies is measured through performance metrics modeled after the six audit control categories contained in GAO's Federal Information Systems Audit Control Manual (FISCAM), i.e. entity-wide security program, planning and management; access controls, system development software controls, segregation of duties; and, service continuity. Independent validation of the effectiveness of implemented management and operational controls is accomplished through on-site assessments conducted by the OCIS Review and Inspection Division.

This standardized, disciplined methodology and continual cycle of activity ensures the involvement and cooperation of senior managers, IT staff, and security personnel in implementing an effective security architecture within the Department.

A. What is the total dollar amount allocated to IT security for this investment in FY 2006?
625,000
Please indicate whether an increase in IT security funding is requested to remediate IT security weaknesses, specifying the amount and a general description of the weakness.
This is not an increase in funding. The requested amount for security funding will be applied to identified priorities such as updating and testing of contingency plans, automating tools for configuration management and audit log features, installing additional physical security controls to safeguard computer rooms, maintaining a secure operational production platform. Additionally, the funding will support updating the system security plan, and independent testing for certification and accreditation activities that will support final certification during the first quarter of FY07.
I/B.2 Please describe how the investment (system/application) meets the following security requirements of the Federal Information Security Management Act, OMB policy, and NIST guidelines:
A. Does the investment (system/application) have an up-to-date security plan that meets the requirements of OMB policy and NIST guidelines?
Yes
What is the date of the plan?
Apr 1, 2002
B. Has the investment been certified and accredited (C&A)? Note: Certification and accreditation refers to the full C&A and does not mean interim authority to operate.
No
Specify the C&A methodology used (e.g., NIST guidance)
The C&P Benefits Replacement System is expected to complete C&A by October 2006, prior to the system being declared fully operational.
OCIS is revising its ITSCAP process to reflect the guidance in Special Publication 800-37, Certification and Accreditation Guidelines for Federal Information Systems, which was finalized in May 2004. This will ensure that program managers can effectively establish minimum security controls for their systems consistent with FIPS Pub 199, Security Categorization of Federal Information and Information Systems and draft SP 800-53, Recommended Security Controls for Federal Information systems, as well as subsequently select a C&A methodology of appropriate rigor and intensity. Utilizing this revised methodology is anticipated to increase the Department's FISMA compliance on a more expedient basis through identifying additional opportunities to use the 'site' and 'type' C&A processes. This will decrease the time required to complete overall C&A activities; increase the ability to leverage financial, personnel and technical resources; and, establish a baseline for consistent, comparable, and repeatable certifications of IT systems in the future.
The project uses metrics to monitor progress in implementing required security controls. The results of the annual survey, and a compilation of deficiencies identified from OIG, General Accounting Office (GAO), and other audit reports and security reviews, have been segmented into 44 discrete security topics, with 36 of these topics representing the critical elements contained in NIST SP 800-26, as well as 8 topics representing the most commonly identified OIG deficiencies. These topics are further segmented into six logical security control areas. These areas were (1) entity-wide security program planning and management; (2) access controls; (3) application software development and change controls; (4) segregation of duties; (5) system software controls; and, (6) service continuity. These security controls areas, which are deemed essential to protecting data integrity, continuity, privacy, and sensitivity, were modeled after the controls contained in GAO's Financial Information Systems Control Audit Manual (FISCAM).
Date of last review?
Oct 31, 2006
C. Have the management, operational, and technical security controls been tested for effectiveness?
Yes
When were the most recent tests performed?
Aug 1, 2003
D. Have all system users been appropriately trained in the past year, including rules of behavior and consequences for violating the rules?
Yes
How has incident handling capability been incorporated into the system or investment, including intrusion detection monitoring and audit log reviews?
The Department has centralized all component incident response capabilities into a single VA-CIRC. Associated guidelines and procedures require that all VA computer security incidents be reported to the VA-CIRC through the facility or office ISO within one business day of the first observation of the incident. VA-CIRC policy requires that, upon identification of an

incident/suspected incident, a preliminary report is generated. For incidents that affect critical systems and/or may have adverse global effects on the VA network, the VA-CIRC will dispatch a 'fly-away' team of technical and forensic experts to assist facility personnel in impact containment. A complete incident report, including a full description of the final incident resolution, is submitted to the VA-CIRC no more than five business days after the incident is resolved by the reporting entity.

The VA-CIRC is also responsible for supplying incident reports to OCIS, the primary organizational contact for the affected organization, and to other VA organizations as appropriate; providing a quarterly report summarizing all incidents to the FedCIRC as provided for in a letter of agreement between VA and the FedCIRC; and, responding directly to FedCIRC inquiries. If an individual incident appears to constitute criminal activity, the facility ISO coordinates the incident with local area law enforcement authorities; and, the VA-CIRC notifies the VA OIG. The OIG provides the necessary federal law enforcement coordination (i.e. Federal Bureau of Investigation, Bureau of Alcohol, Tobacco, and Firearms) although the VA-CIRC does respond directly to federal law enforcement inquiries concerning specific incidents upon request. The Security Operations Center, which is an element of the VA-CIRC, conducts intrusion detection monitoring and audit log analysis for this project, as part of a Department-wide security service provided by OCIS.

E. Are incidents reported to DHS's FedCIRC?

Yes

F. Is the system operated by contractors either on-site or at a contractor facility?

Yes

If yes, does any such contract include specific security requirements required by law and policy?

Yes

How are contractor security procedures monitored, verified, and validated by the agency?

The VETSNET system is operated by an integrated team of contractors and VA staff on-site at 58 VBA regional offices and 3 Network Service Centers (NSC). Contractor activities are closely monitored by the VA supervisors. Security clauses, incorporated into all contracts' requirements, specify the minimum requirements for personnel clearances, as well as data protection, non-disclosure requirements, and training and awareness.

The requirements include:

The contractor shall ensure adequate LAN/Internet, data, information and system security in accordance with VA standard operating procedures and standard contract language, conditions laws, and regulations. The contractor's firewall and web server shall meet or exceed the government minimum requirements for security. All government data shall be protected behind an approved firewall. Any security violations or attempted violations shall be reported to the VA project manager and VA Information Security Officer as soon as possible. The contractor shall follow all applicable VA policies and procedures governing information security, especially those that pertain to certification accreditation.

All contractor personnel assigned to this task will be U.S. citizens. In addition, contract personnel must possess, at a minimum, a current National Agency Check with Inquiries. The contractor shall be responsible for identifying the point of contact within federal agencies where current background investigation information can be obtained for each contractor employee.

All contract employees under this contract are required to complete the VA's on-line Security Awareness Training course annually. Contractors must provide signed certification of completion to the Contracting Officer (CO) during each year of the contract. This requirement is in addition to any other training that may be imposed by contract or other VA organizations.

Contracting Officers (COs) are responsible for ensuring that contractor personnel clearances are received prior to the contractor beginning work with the applications. Because C&P Replacement System and FAS are under development, the contractor monitoring activities are limited to the St. Pete Regional Office.

II.B.3 How does the agency ensure the effective use of security controls and authentication tools to protect privacy for those systems that promote or permit public access?

The Information Security Officers at the 3 Network Service Centers conduct itinerant inspections at the Regional Offices to verify that security controls, policies, and procedures are operative and are being applied as specified by agency guidance. The inspections for Award and FAS, as they are under development, are limited to management and operational controls related to that development.

VETSNET applications are administrative in nature and contain information that requires confidentiality, integrity, and/or availability or must be available to authorized users. This information is critical to VA to conduct claims processing and administrative reporting. Although some information may be used to satisfy public queries and reporting requirements, all information is directly accessed by VA staff and/or sent directly to other government agencies or entities. The C&P Replacement System applications are not accessed directly by the public. Therefore, these applications do not promote

nor permit public access, relieving VA of the requirement to include this investment in the Department's GPEA plan.

II.B.4 How does the agency ensure that the handling of personal information is consistent with relevant government-wide and agency policies.

A security plan, for AWARD (dated September 2001) and FAS (dated April 2002), is in place that documents the procedures required for ensuring the integrity, confidentiality, and availability to VA information. Specifically, personnel security, physical protection, production input/output controls, contingency planning, system hardware and software maintenance controls, security awareness and training, and incident response capabilities are discussed in detail within the Security Plan. The details contained within these sections include specific activities and procedures, which ultimately ensure that the system safeguards protect the integrity, confidentiality, and availability to VA information contained within the system, as required by Federal policy.

II.B.5 If this is a new or significantly altered investment involving information in identifiable form collected from or about members of the public, has a Privacy Impact Assessment (PIA) for this investment been provided to OMB at PIA@omb.eop.gov with the investment's unique project (investment) identifier?

Yes

II. C. Government Paperwork Elimination Act (GPEA)

II.C.1 If this investment supports electronic transactions or record-keeping that is covered by GPEA, briefly describe the transaction or record-keeping functions and how this investment relates to your agency's GPEA plan.

Not Applicable.

II.C.2 What is the date of your conversion from your GPEA plan?

Sep 27, 2002

II.C.3 Identify any OMB Paperwork Reduction Act (PRA) control numbers from information collections that are tied to this investment.

Not Applicable.

PART III.A.1-A.3 (VA SPECIFIC)

1 III.A. Department-Wide Decision Criteria

For detailed definitions of the VA-specific criteria refer to the FY 2005 Capital Investment Guide.

The guide is located at www.capital/budget.

2 III.A.1. Presidential Priorities

Does this project result in increased opportunities for DoD collaboration and/or sharing?

If so, discuss how. Provide copies of signed agreements or other documentation supporting your discussion.

Which of the Department's strategic goals does this project support? (No input required -- populated from Part I)

Select Primary Goal	Select Secondary Goal	Select Tertiary Goal	Select Additional Goal	Select Additional Goal
Quality of Life	One VA			

Discuss in detail how the project will support the Department's strategic goal(s) indicated in the question above. Include appropriate performance baseline measures and goals.

The primary mission of the Department of Veterans Affairs is to "honor, compensate, and care for veterans in recognition of their sacrifice for America." One of the most direct ways in which the Department achieves this mission is through the award and payment of benefits to veterans in the form of compensation and pension (C&P) benefits. The investment proposed in this document is for a system providing automated support to the award, payment, and associated accounting functions for VBA's C&P program. VBA provides 42 million payments to approximately 3.1 million veterans and their dependents annually. Furthermore, this initiative closes the circle of redesign efforts for the end-to-end C&P claims processing cycle: from initial claim application through review, rating, and adjudication to the award and FAS process..

In addition to the clear and direct support that this investment provides in serving a significant number of veterans, the C&P Replacement System will also assist VBA and C&P in performing required recording and monitoring functions to support financial management at both the Administration and Departmental levels. The proposed system will accept the results of the claims adjudication process, calculate and support timely approval of award amounts, generate required payment transactions through Treasury for timely issuance of payment checks and electronic funds transfers, generate the associated audit trail for those payment transactions, and provide automated support for reconciliation, reporting, payment inquiries, and other critical information management functions.

This investment is necessary to replace the current C&P Benefits Delivery Network (BDN) functionality that does not support compliance with federal financial management regulations, does not provide automated support for adequate control over payment processing, and does not support critical customer service needs such as immediate response to payment inquiries and immediate feedback regarding processing errors to allow timely corrections and processing of appropriate payment amounts. The existing system has as its foundation an outdated and complex command driven platform, with negative implications for long-term system life-cycle support (only user of proprietary software and equipment). Furthermore, over the next 3 years VBA's Office of Information Management (OIM) will face a shortage of personnel who are qualified to maintain the legacy system since over half of its personnel are eligible for retirement. Finally, the proposed investment in information technology support for these functions will bring benefits processing for C&P into alignment with broader strategic objectives and information technology standards of the Department and will support wider access to and use of information associated with the processing of C&P payments.

Does this project support opportunities to share or collocate the services and/or costs of capital assets from another administration?

If yes, discuss how.

Does this project assume the services and/or costs of capital assets from another administration?

If yes, discuss how.

III.A.2. Financial Priorities

Data requested for the risk analysis, risk control plan, alternatives analysis, and CEA criteria are required in Part I and used by the Department for evaluation purposes.

Duplication of data is not required.

Cost-effectiveness Analysis (No input required – this data was provided in Section I.E.)

	Element	Alternative 1	Alternative 2	Alternative 3	Alternative 4
		Status Quo - Baseline	Custom Build	Upgrade BDN	Hybrid: Custom Build/COTS
1	System Investment	0.000	27.678	18.507	24.947
2	System Operations and Maintenance	77.748	28.453	73.332	32.730
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13	Alternative Total	77.748	56.132	91.838	57.677

5

Alternatives Analysis (No input required – this data was provided in Section I.E.)

Alternative	Description
-------------	-------------

	Name	
Alternative 1	Status Quo - Baseline	The status quo involves maintaining the systems, processes, and staff in the current environment. The award, payment, and accounting functions for C&P are currently performed using the Benefits Delivery Network (BDN). The BDN comprises multiple hardware and software platforms, and a communication infrastructure that supports critical VBA functions. It also enables distribution of over 42 million payments each year to 3.1 million veterans. The term 'BDN' refers to hardware and software platforms, and communication infrastructure is essential to support the functions of the C&P service.
Alternative 2	Custom Build	This alternative involves completing the software development of the Award and FAS modules of C&P Replacement System.
Alternative 3	Upgrade BDN	The Upgraded BDN alternative involves significant redesign of the award, payment and accounting modules of the C&P application.
Alternative 4	Hybrid: Custom Build/COTS	The Custom Build/COTS alternative involves completing the Award components of the C&P Replacement System and acquiring a COTS software product to replace the payment and accounting functionality. In addition, development of a middleware application will be required to interface the hybrid system with existing internal and external interfaces. This factor may require extensive analysis and design to the integration phase of the project.

6						
Risk Analysis (No input required -- this data was provided in Section I.F.)						
	Date Identified	Risk Category	Description	Probability of Occurrence	Strategy for Mitigation	Current Status, as of the Date of this Exhibit
1	Jun 1, 2003	Schedule	Changes to VBA standards and infrastructure may require additional effort	High	Detailed project schedules and resources analyses are conducted to identify and track critical path and dependencies. The project team will coordinate with other VBA technology projects that will have an impact on delivery schedule (Sun migration, Windows 2000, etc.) ensure schedules are reconciled and resource estimates incorporated into schedule. Different contract types can be explored to encourage more proposals from contractors.	Business Sponsors and OIM consistently review business requirements and analyze the strategy to ensure timely delivery and reasonable expectations.
2	Jun 1, 2003	Initial Costs	Cost overruns due to evolving requirements	Basic	Develop, establish, and implement change control board and change management procedures. Monitor plan versus actual budget by contract deliverable.	VETNET cost baselined: Dec. 31 2002; planned versus actual cost updates provided to PMO by Project Managers at the

						15th of each month
3	Jun 1, 2003	Life-Cycle Costs	Cost overruns due to evolving requirements	Basic	Develop, establish, and implement change control board and change management procedures. Monitor plan versus actual budget by contract deliverable.	VETNSET cost baselined: Dec. 31 2002; planned versus actual cost updates provided to PMO by Project Managers at the 15th of each month
4	Jun 1, 2003	Technical Obsolescence	System will not support business processes	Medium	Consistent business process help to reach uniformity will mitigate this risk. Rigorous testing will minimize "surprises" come deployment. The project team will maintain, update, and adhere to the development methodology and standard development process that has been implemented. The VA's Technical Resource Model and Standards Profile (TRM) provide a baseline of standards that is used throughout the VA organization. Compliance with these standards ensures that the system provides an interface that is consistent with other VBA systems, VA systems, and other external systems.	VBA is developing a Succession Plan for OIM personnel. VBA is reviewing the possibility of supplementing current personnel with contractor support as well as retention bonuses for current staff to assist in maintaining a knowledge base.
5	Jun 1, 2003	Feasibility	Effort does not support an enterprise approach to application development	Basic	The system is based on the corporate data model developed during the Requirements Analysis phase. This model contains entities, attributes, and relationships that span the entire scope of VBA operations. The design of this model allows for a flexible system that can adapt to VBA's requirements and maintain interoperability among the various systems. The development methodology used relies heavily on the interaction and input of the business/functional experts and the user community, thereby ensuring that user expectation and needs	User testing and training are integrated into the overall project management plan.

					will be met by the completed application.	
6	Jun 1, 2003	Reliability of Systems	System will not function as specified or suffer shortfall(s) in performance.	Basic	VBA plans to perform benchmark modeling and simulation studies.	Load testing to be conducted before National Rollout - Testing contractor support procured for the effort.
7	Jun 1, 2003	Dependencies & Interoperability Btw. this Investment & Others	Effort does not support an enterprise approach to claims processing	Basic	The system is based on the business model developed during the Requirements Analysis phase. This model contains relationships that span the entire scope of related VBA applications. Similarly to the technical aspect of the data model, the design of this model allows for a flexible system that can adapt to VBA's requirements and maintain interoperability among the various systems. The development methodology used relies heavily on the interaction and input of the business/functional experts and the user community, thereby ensuring that user expectation and needs will be met by the completed application.	Dependencies and relationships between C&P Benefits Replacement and other VBA applications are integrated into the overall project management plan.
8	Jun 1, 2003	Surety (Asset Protection) Considerations	Lack of change controls for monitoring of security flaws and attention to C&A processes	Medium	A security plan and schedule are developed to ensure that risk assessments and certification and accreditation are conducted in a timely manner and prior to production.	VBA is securing funding to provide certification and accreditation support to all system owners to update and/or develop the required documentation, and to conduct certification activities.
9	Jun 1, 2003	Risk of Creating a Monopoly for Future Procurements	The Government will become dependent on one contractor for completing the project	Medium	Requirements defined by business lines that, in connection with guidelines from FFMSR and through the JFMIP, continue to track the adherence of compliance.	Tracking deliverables by Task Order Project Manager.
10	Jun 1, 2003	Capability of Agency to Manage the Investment	Loss of key functional expertise may affect management effectiveness	Basic	Departmental reorganization efforts may shift program responsibility more towards OIM than the business lines; likewise, there are efforts to	Reorganization efforts have been implemented with minimal disruption to service.

					restructure the St. Petersburg System Development Center (SPSDC).	
11	Jun 1, 2003	Overall Risk of Project Failure	Applications will not support VA Departmental objectives	Basic	Develop requirements and validate development based on VA/VBA Strategic and Tactical Plans. Obtain all Departmental requirements in relation to the Milestone approval process	Received System Development Approval (Milestone II)
12	Jun 1, 2003	Organizational & Change Management	Project will lose management support	Basic	This is a top priority of the Undersecretary for Benefits. VBA has established an Executive board that meets regularly to discuss to all MAP components including the Compensation and Pension Replacement System.	Weekly Project Control Board Meetings; Monthly Executive Board Meetings; Weekly Status Update sent to Undersecretary for Benefits
13	Jun 1, 2003	Business	System will not be accepted by users	Medium	Develop Change Management and marketing strategy to 'sell' C&P replacement applications and processes. Develop a system based on the standardized, corporate data model. This model contains entities, attributes, and relationships agreed to by both IT and business representation. Incorporate a flexible application design, allowing for adaptability to VBA's requirements and interoperability.	User testing and training are integrated into the overall project management plan.
14	Jun 1, 2003	Data/Info.	Increased number of data sources including internal databases and external verification activities	High	Develop applications in accordance with Departmental Enterprise Architecture standards and procedures. Follow a consistent software development methodology.	Monitoring and synchronizing legacy and current environment
15	Jun 1, 2003	Technology	VBA lacks experience with the technology being used	Medium	Consistent business process help to reach uniformity will mitigate this risk. Rigorous testing will minimize "surprises" come deployment. The project team will maintain, update, and adhere to the development methodology and	VBA is developing a Succession Plan for OIM personnel. VBA is reviewing the possibility of supplementing current personnel with contractor support as well as retention bonuses for current staff to

					standard development process that has been implemented. The VA's Technical Resource Model and Standards Profile (TRM) provide a baseline of standards that is used throughout the VA organization. Compliance with these standards ensures that the system provides an interface that is consistent with other VBA systems, VA systems, and other external systems.	assist in maintaining a knowledge base.
16	Jun 1, 2003	Strategic	Inadequate risk assessments	Basic	The system is based on a corporate data model developed during the requirements analysis phase. This model contains entities, attributes, and relationships that span the entire scope of VBA operations.	The design of this model allows for a flexible system that can adapt to VBA's requirements and maintain interoperability among various systems.
17	Jun 1, 2003	Security	Disclosure of private data	Basic	A security plan and schedule are developed to ensure that risk assessments and certification and accreditation are conducted in a timely manner and prior to production.	VBA is securing funding to provide certification and accreditation support to all system owners to update and/or develop the required documentation, and to conduct certification activities.
18	Jun 1, 2003	Privacy	Difficulty securing contractors and limited contracting expertise in Task Order Managers	Medium	Solicit contractor support early in development lifecycle. Establish business relationships VA Departmental Security Office in order to leverage existing successful contract efforts.	Defined as a requirement
19	Jun 1, 2003	Project Resources	Underestimate level of effort due to evolving requirements	Medium	The project management is employing Earned Value Management. A cost benefit analysis was completed has been conducted with a 10 year lifecycle and a sensitivity analysis which show potential cost impacts of changes in cost assumptions. If the scope threatens to expand or additional implementation actions are identified that were not included in the initial plan, the Executive	Fixed price contracts are being used when feasible. This project has a VBA Program Analyst assigned to monitor and track the budget and expenses.

					Steering Committee and Project Control Board will take appropriate action to allow or deny these actions and will exercise their authority to obtain additional resources as needed.	
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R
<i>Risk Control Plan (Provide completed Risk Analysis template w/ Risk Control items completed for the chosen alternative only)</i>
Jun 1, 2003
<i>Does this project result in any savings and/or cost avoidance?</i>
<i>If so, explain the savings and/or cost avoidance and provide data and calculations to support your discussion.</i>
<i>Describe the exit strategy or the planned methodical disposal implementation plan that will be set in motion at the end of the useful life of the project.</i>

III.A.3. Capital Asset Priorities/Portfolio Goals						
<i>Capital Asset Portfolio Goals</i>						
<i>Identify the Primary, Secondary, Tertiary and any additional goals supported.</i>						
Primary Goal	Secondary Goal	Tertiary Goal	Additional Goal	Additional Goal	Additional Goal	Additional Goal

PART III.A.4 (VA SPECIFIC)

III.A.4. Capital Asset Priorities/Portfolio Measures		
Note: See guidance for additional detail on Capital Asset Priorities/Portfolio Measures (see the Attachments form tab)		
Increase Intra/Inter-agency and Community Based Sharing (For sharing opportunities not covered under Presidential/Secretarial Priorities)		
This project results in an 1) increase of assets shared across all VA business lines; 2) an increase of assets shared with state and local communities; 3) increase of assets shared across other Federal Agencies (non-DoD); 4) None of the above. (Select all that apply)		
Select	Select	Select

III.A.4. Capital Asset Priorities/Portfolio Measures	
If any of the above apply, discuss in detail, provide current baseline (number and size, i.e., dollar amounts) of assets shared, and how asset improves the current baseline (show % change from baseline). Provide backup documentation.	
Decrease Underutilized Capacity	
This project results in 1) a decrease in vacant or underutilized assets; 2) an increase in asset sales; 3) None of the above. (Select all that apply)	
Select	Select

III.A.4. Capital Asset Priorities/Portfolio Measures			
If any of the above apply, discuss in detail, provide current baseline (current underutilized space and associated costs) and how capital asset improves the current baseline (show % change from baseline). Provide backup documentation.			
Decrease Operational Costs			
This project results in 1) lower operational costs; 2) decreases in assets that have exceeded their useful life; 3) elimination of data source redundancy (IT); 4) a general decrease in the total cost of asset ownership; 5) None of the above. (Select all that apply)			
Select	Select	Select	Select

III.A.4. Capital Asset Priorities/Portfolio Measures
If any of the above apply, discuss in detail, provide current baseline of the above measures, and how asset improves the current baseline (show % change from baseline). Provide backup documentation.

Reduce Energy Utilization

This project results in 1) an increase in renewable energy usage; 2) a decrease in total energy consumption (volume); 3) a decrease in the unit cost of energy; 4) None of the above. (Select all that apply)

Select	Select	Select

If any of the above apply, discuss in detail, provide current baseline of the above measures and how asset improves current baseline (show % change from baseline). Provide backup documentation.

Increase Revenue Opportunities

This project results in 1) an increase in revenue opportunities for enhanced-use lease projects; 2) increased vacant space that is out-leased or shared; 3) None of the above. (Select all that apply)

Select	Select

If any of the above apply, discuss in detail, provide current baseline of above measures and how asset improves current baseline (show % change from baseline). Provide backup documentation.

Maximize Highest and Best Use

This project results in 1) an increase in the number of agreements for asset exchanges/sales to acquire replacement property better suited for mission purposes; 2) an increase in the number of out-leases; 3) a balance of spending distribution to ensure portfolio management; 4) None of the above. (Select all that apply)

Select	Select

If any of the above apply, discuss in detail, provide current baseline of above measures and how asset improves current baseline (show % change from baseline). Provide backup documentation.

Safeguard Assets (This sub-criteria is addressed in Section III.A.4. below. It is listed here because it is one of the capital asset priorities/portfolio goals, but it is also considered important enough to be addressed as a separate criterion.)

PART III.A.5-B (VA SPECIFIC)

III.A.5. Safeguard Assets

Safety: This project improves compliance with 1) safety (exclusive of seismic); 2) access; 3) accreditation laws and regulations; 4) None of the above. (Select all that apply)

Select	Select	Select

If any of the above apply, describe how the project will dedicate at least 50% of the investment value to improving compliance with safety (exclusive of seismic), accessibility and/or accreditation laws and regulations.

Seismic: Does this project ensure that the VA's infrastructure is seismically sound?

If so, provide supporting evidence to show how at least 70% of the project's investment cost supports the seismic criterion.

Identify the degree of seismic deficiency (the ranking from the latest Degenkolb study).

Provide date of Degenkolb study.

Security: This project 1) supports the Department's ability to respond promptly and comprehensively in the event of a national emergency or natural disaster; 2) ensures security of physical assets; 3) ensures security of IT infrastructure assets; 4) None of the above. (Select all that apply)

Select	Select	Select

If any of the above apply, describe how the project will dedicate at least 50% of the investment value to resolving a security deficiency.

III.B. Non-CARES Decision Criteria

Customer Service

Will this project result in an increase in new customers?

If so, discuss in detail and provide supporting documentation.

Will this project improve customer satisfaction?
If so, discuss in detail and provide supporting documentation.
Will this project improve customer access?
If so, discuss in detail and provide supporting documentation.

Special Requirements for All Investment Proposals				
<i>IT WORKLOAD: Provide an estimate of projected workload (transactions, rewrite lines of code, telephone traffic, etc. Use workload data pertinent to IT investments).</i>				
<i>For VHA Non-CARES, NCA, VBA and Staff Offices workload: Provide an estimate for population supported for 2005, 2010, 2015, and 2020. Include service connected and other Category A populations to be served.</i>				
Population/Area	2005	2010	2015	2020

EXHIBIT 53**Item Name**

C&P Benefits Replacement System-2006

*Former name of the initiative if changed from last year.***Basic Information****OMB Exhibit 53 Code:**

029-00-01-13-01-1380-00-101-003

Investment Type:

Major IT Investment(01)

Initiative Short Description (100 words max)

VETSNET Compensation and Pension (C&P) is a streamlined information system that establishes, develops, and rates a claim, prepares award, notifies the veteran, and generates payment information.

FEA BRM Line of Business and Sub-Functions (from exh 300 part II)

	Line of Business / Sub-Function list	Mode of Delivery
1	Community & Social Svcs/Social Svcs	Direct Service to the Citizen/Civilian Operations
2	Litigation&Judicial Activities/Judicial Hearing	Direct Service to the Citizen/Civilian Operations
3	Litigation&Judicial Activities/Resolutn Facilitatn	Direct Service to the Citizen/Civilian Operations
4	Financial Mgmt/Reporting and Information	Direct Service to the Citizen/Civilian Operations
5		
6		
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16		

GOE-O/Management	029-40-0151										
GOE-OGC	029-40-0151										
GOE-OT+T	029-40-0151										
GOE-OIG	029-40-0170										
GOE-P+IA	029-40-0151										
GOE-OP+P	029-40-0151										
GOE-Oth Staff Offices	029-40-0151										
GOE subtotal		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

Budget Account Summary											
Budget Account Name	Budget Account Code	Total Inv PY 04	Total Inv CY 05	Total Inv BY 06	Total DME PY 04	Total DME CY 05	Total DME BY 06	Total SS PY 04	Total SS CY 05	Total SS BY 06	
Medical Services	029-15-0160										
Medical Research	029-15-0161										
Medical Administration	029-15-0152										
Medical Facilities	029-15-0162										
VBA Compensation	029-25-0134	11.784	5.976	5.980	11.784	5.976	0.000	0.000	0.000	5.980	
VBA Pension	029-25-0143	2.946	1.494	1.490	2.946	1.494	0.000	0.000	0.000	1.490	
VBA Education	029-25-0133										
VBA Voc Rehab and Employment	029-25-0132										
VBA Insurance	029-25-0141										
VBA Housing	029-25-1119										
NCA Burial Administration	029-25-0129										
GOE-OIG	029-40-0170										
GOE-Other	029-40-0151										
Budget Account Total		14.730	7.470	7.470	14.730	7.470	0.000	0.000	0.000	7.470	

PRIVACY IMPACT ASSESSMENT

Project Identifying Information	
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Exhibit 300 Initiative (Item Name):	C&P Benefits Replacement System-2006
OMB Unique Project Identifier:	029-00-01-13-01-1380-00-101-003
Proj. Mgr. 1 Name:	Thompson, Dianne
Proj. Mgr. 1 Phone:	202-273-6865
Proj. Mgr. 1 E-mail:	irmdthom@vba.va.gov

Qualifying Questions	
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	<i>A Privacy Impact Assessment is required for all VA projects with IT systems that maintain Personally Identifiable Information (PII) of the public of at least ten individuals in the public, not counting Federal employees and others performing work for VA (Contractors, interns, volunteers)</i>
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	<i>(Please indicate whether your project meets the criteria requiring a PIA)</i>
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Required to Complete a PIA:	Yes
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	<i>If you are required to complete the Privacy Impact Assessment (answer is Yes), then complete the remaining questions on this form.</i>
--	---

Privacy Impact Assessment Questions	
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1.	<i>What individually identifying information is collected? Indicate Yes or No for the following groups of information.</i>
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	<i>For the following information categories, indicate whether your system collects that type of information:</i>
--	--

Personal Info Collected:	Yes
---------------------------------	-----

Dependent Info Collected:	Yes
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Service Info Collected:	Yes
--------------------------------	-----

Medical Info Collected:	Yes
--------------------------------	-----

Criminal Record Info Collected:	Yes
--	-----

Guardian Info Collected:	Yes
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Education Info Collected:	No
Rehabilitation Info Collected:	No

	<i>If other information is collected not covered by the types listed above, check Yes and briefly identify that type of information.</i>
Other Personal Info Collected:	No
Other Personal Info Description:	

1.a	<i>Enter number of individuals that are expected to have their personal information stored in project systems (actual or approximate).</i>
	16,000,000

1.b	<i>What are the sources of the information collected?</i>
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Veteran Source:	Yes
Public Source:	Yes
Other Federal Agency Source:	Yes

State Agency Source:	Yes
Local Agency Source:	Yes
Contractor Source:	No

	<i>If another source supplied the information that is not covered by the sources listed above, check Yes and briefly identify that source of the information.</i>
Other Source:	No
Concise narrative answer:	<p>Most information is provided directly by the veteran. Data will be, when this system is fully implemented, collected from Bureau of Prisons, American Red Cross, National Service Life Insurance (NSLI), Blinded American Veterans, Bureau of the Census, Veterans Government Life Insurance (VGLI), Bureau of Prisons, Veterans Mortgage Life Insurance (VMLI), Department of Defense (DoD), Department of Labor, Department of Treasury, Federal Parent Locator Service, General Accounting Office, Office of Inspector General, Office of Personnel Management, Small Business Administration, and Social Security Administration (SSA).</p> <p>The information collected includes:</p>

<p>Veteran Personal data: Name, Address, Social Security Number, Family/Dependents, Marital Status, Medical Status, Birth Information, Death Information Service Data: Reserve and Guard Participation, retired pay or severance pay, hazardous agent exposure, Branch of service, duty date, released date, type of discharge, separation reason</p> <p>Medical Records: Military clinical records, government health records, vocational rehabilitation and employment records, line of duty investigations</p> <p>Police Records: Incarceration at federal state or local facility, fugitive felon status, investigative reports for some accident</p> <p>Guardian Information: Court proceedings, field examinations, appointment and bonding of fiduciaries, annual accountings</p> <p>Veteran Dependent Data: Personal information including name and address, age, school status, relationship to the veteran, medical status</p> <p>Account History: case/account number, identity of beneficiary, eligibility determination information, benefit information</p> <p>Education Program Approval Information: Approved courses, effective dates, types of training, facility code, objective code, training type</p> <p>Rehabilitation Program Approval Information: Institution certifications, licenses, approval information</p>
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1.c	<i>What is the collection media of the information collected?</i>
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Web Forms Media:	Yes
Paper Forms Media:	Yes

Computer Transfer Media:	Yes
Telephone Contact Media:	Yes

	<i>If another media is used to collect the information that is not covered by the media listed above, check Yes and briefly identify the media used to collect the information.</i>
Other Media:	No
Concise narrative answer:	<p>The VBA website is http://www.vba.va.gov; with the specific online form located at http://vabenefits.vba.va.gov/vonapp/main.asp. The available forms located at this site are: V A Form 21-526, Veteran's Application for Compensation and/or Pension. Applicants are required to complete form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (V A). All VBA benefit forms are located at http://www.vba.va.gov/pubs/forms1.htm.</p> <p>The VBA toll free number for benefits is 1-800-827-1000.</p>

2.	<i>Why is the information collected?</i>
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Concise narrative answer:	This information is collected in support of the receipt, processing, tracking and disposition of veterans' applications for benefits and requests for assistance, and the general administration of legislated benefit programs
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3.	<i>What is the intended use of the information?</i>
	Determine and/or provide for other veteran benefits
	<i>Is there other usage of the information? If so, briefly define the usage below.</i>
	No
Concise narrative answer:	The information is used to determine eligibility for benefits, process ratings, and to provide payments via Department of Treasury. Other mail might inform veterans of changes in account status or advise about new options.

4.	<i>With whom will the information be shared? (other agencies, organizations, systems, etc.)</i>
Veteran Organization:	Yes
Public :	No
Other Federal Agency :	Yes
State Agency :	Yes
Local Agency :	Yes
Contractor :	No
Concise narrative description including the names of entities and any agreements regarding the sharing of PII:	
PII - narrative description (names, entities, agreements):	This system has documented Memorandums of Understanding/Agreement with all of its business partners, including veteran organizations, federal agencies, state agencies, and local agencies in regard to confidential business information, Privacy Act, and certain information that is subject to confidentiality protections. This includes all the entities mentioned previously within this document and includes the Department of Defense, the Social Security Administration, Educational Institutions, Federal Housing Administration, Internal Revenue Service and the Department of Housing and Urban Development. A detailed listing of all business partners is available from the project manager. VBA has emplaced strict control measures to prevent the inadvertent or deliberate release of information to non-authorized personnel.

5.	<i>How will individuals provide consent for collection and use of their personal information?</i>
Concise narrative answer:	<p>Individuals provide consent through the use of signed consent forms, through notarized indication of a Power of Attorney or through authorized or verified signature. Regardless of the media, consent is collected through submission of electronic forms marking consent approval, verbal authorization, or through Memorandums of Understanding with business partners. VA requires that all consent forms be documented and authorized or verified signatures are required. In addition, limited consent is provided as part of routine use as specified in various Privacy Act System of Record notifications.</p> <p>The collection site provides a link to VA's privacy and security statement located at http://www.va.gov/privacy/. This statement states that "the privacy of our customers has always been of utmost importance to the Department of Veterans Affairs. The VA has a long</p>

	<p>history of protecting your privacy and our concern for your privacy is no different in the electronic age." It also explains the VA's Internet privacy policy.</p> <p>The collection site also provides a link to VA's information on the Freedom of Information Act located at http://www.va.gov/foia/. The site also provides a link to VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA), which is a requirement.</p>
	Based on your answer above, please select the applicable answer from the answer below.
	Multiple Forms Used

6.	How will the information be secured?
Concise narrative answer:	<p>All information stored in VBA databases is secured in agreement with VA strategy. This strategy implements Federal Regulations, VA IT security policy and guidelines, NIST Guidelines and industry best practices. Security is implemented in compliance with VA's Office of Cyber and Information Security (OCIS) guidelines, policies, and mandates. With guidance from OCIS, the VBA administers and monitors security controls on multiple operating levels including the managerial, operational and technical levels. This System uses strong passwords. Access is granted on the principles of least privilege and separation of duties. Users have completed ethics training, annual cybersecurity training, and have signed rules of behavior.</p> <p>All security controls are implemented through a cohesive security structure and is geared to maintaining risk to information and information resources to acceptable levels. In addition to documented risk management, other management level controls such as system security planning, certification and accreditation and security reviews are also implemented to assure that controls reflect management policies at operational levels including at the enterprise, business line and project level. Operational and technical controls such as contingency planning, input/output settings, data integrity and validation measures and logical access controls, are implemented on the various network, system, server and application levels to assure that information is secured in transit, process and storage. For example, the VA employs a virtual private network to assure the privacy of information in transit. This system works in conjunction with strong authentication measures to ensure and authenticate the identification of VA network users.</p> <p>System interconnection agreements (SIA)s are a system level measure to ensure that all interconnected systems meet minimum VA access policies for interconnected systems from within and outside the VA wide area network (WAN) boundaries. Moreover, the VA employs a comprehensive incidence response unit to respond to unwanted incursions and institutes enterprise level anti-virus system to protect mission critical applications on the desktop. Finally, the VA security program is an iterative program with repeatable processes that, in an ongoing basis, will mitigate vulnerabilities, minimize security exposures and maintain security and operating risk at acceptable levels.</p> <p>A security plan has been developed that documents the procedures required ensuring the integrity, confidentiality, and availability to VA information. Specifically, personnel security, physical protection, production input/output controls, contingency planning, system hardware and software maintenance controls, security awareness and training, and incident response capabilities are discussed in detail. The details contained within these sections include specific activities and procedures, which ultimately ensure that the integrity, confidentiality, and availability to VA information contained within the system is protected as required by Federal policy. All files, records, reports, and other papers and documents pertaining to any claim under any of the laws administered by the Department of Veterans Affairs and the names and addresses of present or former members of the Armed Forces, and their dependents, in the possession of the Department shall be confidential and privileged. This specifically includes all individually identifiable health information of a veteran, which is stored electronically and in hard copy form. All works or items of intellectual property used, transmitted, stored, or disseminated by the Department as part of the this initiative, in any form, including electronic or physical, will be used in conformance with laws and regulations applicable to copyright, patent, trademark, or licensing of such works.</p>

7.	<i>Is this system or collection part of a Privacy Act System of Records?</i>
Concise narrative answer:	Yes this collection is part of a Privacy Act System of Records
	<i>If applicable, please provide the SOR Identifier.</i>
	58VA21

8.	<i>Identify what choices were made regarding an IT system or collection of information as a result of performing the PIA.</i>
Concise narrative answer:	As a result of performing the PIA, continual emphasis and attention will be applied to addressing security and privacy concerns including assuring that collection of data and personal information contains appropriate consent and release information and that all information stored in VBA databases are secured per VA security standards.

PIA Completion Certification	
	<i>When all answers have been answered completely and the assessment is ready for review by security, please indicate by answering YES below.</i>
Answers complete?	Yes

Review Status	
PIA Review Status:	Pass
PIA Review Comments:	<p>Question 1: No additional information required.</p> <p>Question 1.a: Note: The question asks that the response be given in thousands. Because of the confusion caused by some expressing the number in its actual form and some expressing it in thousands, the PIA form has been changed to remove the requirement that this number be expressed in thousands. Please verify that the correct number of records in the system is (or is expected to be) 16,000,000 (sixteen million).</p> <p>Question 1.b: In the "Concise narrative answer" field, please specifically identify each data source (i.e., each agency, each contractor, etc.)</p> <p>Question 1.c: In the "Concise narrative answer" field, please identify the URLs of each website from which web form data was collected. Please identify the paper forms by which data was collected. This information will assist in determining the scope of consent given, based on privacy policies and disclosures made to the data subject at the time of collection.</p> <p>Question 2: No additional information required.</p> <p>Question 3: Please provide a more detailed and specific response. If multiple classes of information are being collected, and different classes of information are being used for different purposes, or if different data fields are being used for different purposes, please describe such distinctions here. (For example, if name and address are being used to communicate with the individual via postal mail, and criminal record information is being used for a different purpose, state this distinction.)</p> <p>Question 4: Please list each agency with which personal information will be shared specifically. Please identify any contractors or partners with whom information will be shared, and identify the agreements covering each relationship. Avoid the use of open-</p>

ended qualifiers such as "include, but are not limited to". The purpose of this paragraph is to get an accurate assessment of information sharing, rather than a general acknowledgement that the data is, in fact, being shared.

Question 5: Please provide some additional information describing how individuals have provided consent for collection and use of their personal information. With respect to data collected via web forms, please describe the affirmative act by which the data subject expressed his or her consent, and include a link to the appropriate privacy statement or policy accessible from the collection site.

For example, such a response might read: "Personal information was collected via a web-based form at <http://www.va.gov/coox.asp>. [example only] That site contained a link to the VA website privacy statement located at <http://www.va.gov/privacy/email.htm> [example only], which specifically stated that, by submitting his or her information, the individual was consenting to the use of such information for the purposes described in this document. By clicking on the "submit" button on the web-based form, the individual expressed his or her consent to the terms of the privacy statement."

If consent was given pursuant to a VA policy (e.g., as a precondition of receipt of benefits) or other document to which the data subject had access, please reference such document(s) here.

Question 6: Please ensure that your response to this question is limited to specifically describing how the information in the system being described in this PIA is being secured (rather than describing VA information security in general). Please refer to OMB guidance in the Memorandum from OMB Director Joshua B. Bolten, "OMB Guidance for Implementing the Privacy Provisions of the E-Government Act of 2002" (undated). (Response may be limited depending on the stage of development of the system)

Question 7: No additional information required.

Question 8: No additional information is required.


**PIA Reviewer Name &
Phone #:**

Helen Granito, 202-273-9291

PIA Review Status Date:


Jul 30, 2004

ATTACHMENTS

 **Exhibit 300 Attachments**

In the following table, please upload your Cost Benefit Analysis, Risk Analysis, and Acquisition Plan documents, as well as any other pertinent documents related to this initiative.

Name	Link	Size	Owner	Uploaded
CPReplace EIB Summary	https://vaww.camsit.aac.va.gov/IDR/gd.asp?docId=16	162 KB	Kathryn Miller	Jun 21, 2004 12:00 AM

 **Security Plan Attachments**

In the following table, please upload your Security Plan document(s). The Security documents can only be accessed by the users with create access for this project and OCIS Reviewers.

Name	Link	Size	Owner	Uploaded

**Questions for the Record
Honorable Lane Evans
Committee on Veterans' Affairs
February 16, 2005
Hearing on Department of Veterans
Affairs
Fiscal Year 2006 Budget**

Question 9- Attachment

**DRAFT Risk Assessment Plan and
Analysis
for VETSNET**

Department of Veterans Affairs Veterans Benefits Administration



Veterans Service Network VETSNET

Project Management Plan

Project Name	Project Reference Number	Prepared By	Preparer's Initials
Veterans Service Network	None	VBA PMO	NIL
Managing Organization	Contact	Contact's Phone	Date Prepared
VBA OIM	Pamela Zadak	(708) 681 - 6773	February 23, 2005

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Preface

This Project Management Plan (PMP) updates and outlines the strategy and framework supported by processes, procedures, schedules, and reports that will collectively ensure successful management of VBA's Veterans Service Network (VETSNET).

The PMP includes management baselines required to compare actual project performance against the original plan.

The PMP is maintained by the respective Project Team (PT) and is updated as project changes warrant. All personnel assigned to the project are provided a copy of the PMP and are responsible for implementing and adhering to the policies and procedures contained in the PMP.

This PMP is an update to the previous VETSNET Project Management Plan dated January 10, 2003. It incorporates programmatic updates needed to reflect the current management strategies, technical development strategies, and overall implementation strategies based on the successful deployments of key VETSNET application suite features and capabilities as well as the ongoing plans for additional VETSNET production testing and full scale deployment.

The PMP is evolutionary in design and intent, and will be updated to include lessons learned from each major milestone accomplishment. The primary emphasis is on the importance of minimizing or eliminating adverse impacts to veterans and to the VBA workforce, as well as the importance of training and deployment preparation, including how to add records systematically at each Regional Office (ROs), how to systematically add ROs with the least possible disruption to the claims processing workload.

Executive Summary

The Veterans Service Network (VETSNET) is a system of integrated applications to replace the Benefits Delivery Network (BDN). BDN is a legacy system that has been used several years by the Veterans Benefits Administration (VBA) to process and pay claims for VBA benefits.

Three of the five major applications of VETSNET are already being used in all Regional Offices (RO) as the basis for claims processing (i.e., Search and Participant Profile, which records and updates basic information about veterans and their dependents; Modern Award Processing-Development, which develops the claim and Rating Board Automation 2000, which rates the claim).

All five VETSNET applications (including Award, which prepares the award and the Financial Accounting System, which pays the claim) are being used by the Lincoln and Nashville ROs to pay electronic funds transfer disability compensation claims for veterans with dependents who are rated from 10% through 100% (except for apportionment). VBA is planning to complete full deployment of VETSNET to all regional offices by December, 2006.

This Project Management Plan is a key component of an overall VBA commitment to improved management oversight of a critical business asset, the Veterans Service Network. The primary goal of implementing VETSNET is to minimize or eliminate all adverse impact to veterans and their dependents and to the VBA workforce during the transition from BDN to VETSNET.

This goal is consistent with VBA's intent that the processing of claims in the most timely manner possible remains the highest priority of VBA. Accordingly, VBA has developed a systematic approach to VETSNET that is based on lessons learned from (1) previous development and deployments of VETSNET applications, (2) CoreFLS and (3) analyses of the Federal Bureau of Investigation Trilogy project.

This systematic approach has included upgrading the legacy system (Benefits Delivery Network or BDN) so that BDN could remain operational and as reliable as possible until VETSNET is fully deployed and in use by all regional offices. This effort was based on the recommendations from the Claims Processing Task Force to develop an "insurance policy" for BDN. It included upgrades of the BDN hardware and software, simplification of the BDN job streams and the payment of retention bonuses to key individuals at the Hines Information Technology Center (ITC) in order that VBA would have qualified workers for legacy system support. Also, in order to simplify the workload of the Hines ITC, we have reduced the number of releases of new software by scheduling them on a quarterly rather than monthly basis.

VBA has systematically and methodically introduced the new VETSNET applications into the VBA workforce in an orderly fashion that corresponds to the steps in the claims processing work flow. From the technical perspective, these applications have been developed with input from the end users and business lines and have been extensively tested by independent contractors, business line users and also end users in regional offices. Furthermore, as these VETSNET applications have transitioned from development into deployment and use in the regional offices, responsibility for their operation and maintenance has been transferred to the Hines ITC.

From the business perspective, these applications have been systematically introduced into the workforce in such a way as to minimize the adverse impact to the workforce. This introduction has included systematic training of key individuals and the methodical insertion of the new applications into the claims processing workflow.

This Project Management Plan is focused on the completion of the remaining milestones necessary for successfully achieving the goal of full VETSNET deployment to all regional offices by December, 2006. The three major elements of this are (1) planned quarterly releases to deploy full VETSNET functionality to all regional offices, (2) training of the VBA workforce in order to accomplish the successful absorption of this new technology and (3) deployment preparation to ensure that all regional offices successfully absorb this new technology with the least possible adverse impact on veterans and the VBA workforce.

Individual portions of this Project Management Plan address the following specific areas of VETSNET: (1) VBA's approach in deploying VETSNET, (2) VETSNET management strategy, (3) internal controls, (4) schedule, (5) training, (6) cost management, (7) risk management, and (8) communications plan.

Cost Management

This section describes cost and budget considerations and the process to report status and cost information for the project. This information will be available to and used by the VETSNET team leaders to understand how they are interrelated and how VETSNET resources are being used.

Cost and Budget Overview

VBA Office of Information (OIM) will be responsible for the annual recurring and maintenance costs associated with developing the VETSNET system. Additionally, with the support of the Business Sponsors, OIM will refresh the Exhibit 300 as needed.

Cost Control

The actual costs of the project will be reported and compared to the budgeted costs monthly. This information will be limited to the PM, PCB, VEB, and other parties on an as needed basis. IT Project Office will be used to track project costs and expenses. The budget cycle will be used to plan the future costs of maintenance of the VETSNET applications and planned enhancements.

Risk Management

The process of identifying, allocating, managing and minimizing risks is crucial to the success of VETSNET. The ability of the PM to track and understand various risks and then to allocate resources to mitigate them will be a major factor in bringing the project in on time and on budget. The following steps identify the procedures for identifying and tracking VETSNET risks. Identified risks will be tracked using the Risk Assessment Form for Initiative (see Attachment "C") maintained and updated in IT Project Office.

Identified risks and mitigation activities will be addressed at each status meeting with special attention given to risks directly related to project activities currently in progress or anticipated to start prior to the next status meeting.

Risk Identification

As VETSNET progresses, it is assumed that aspects of it will change and evolve. Consequently, the risks that were first identified in the planning phase may be magnified, reduced, or disappear while others surface and must be addressed. Currently, one focus on VETSNET is the area of deployment risk management. Any member of the PT can identify a new risk by completing the Risk Assessment Form for Initiative. This form will ensure a uniform, disciplined approach to documenting risks identified. The use of IT Project Office will provide an automated method of recording and tracking risks. A current risk list is maintained in the Exhibit 300.

Risk Assessment/Quantification

Once identified, the risk will be analyzed and quantified by the PM and the PCB. The PM in association with the PCB and subject matter experts will assign a probability of occurrence and a potential project impact should the risk occur.

The qualitative values for probabilities and impacts:

<u>Probabilities</u>	<u>Impacts</u>
High (Very Likely)	High
Medium (Probable)	Medium
Low (Possible)	Low

Risk Allocation

Once risks have been identified, they will be assigned to specific team members for monitoring. If the risk does manifest, the team member assigned to the risk, or risk owner, shall alert the PM. Upon receiving guidance from the PM, the risk owner will be responsible for application of the identified mitigation strategies.

Risk Containment

At the direction of the PM, mitigation plans will be developed for each identified risk. The PM is responsible for overall risk and mitigation analysis and prioritization. The prioritization process will be useful in ensuring the number of strategies competing for resources will be manageable. Risks will be monitored across the project lifecycle.

Currently Identified Risks

The following table summarizes the currently identified **high** risks and who "owns" the risk. All risks are detailed and managed in IT Project Office. They may be found in the Exhibit 300.

[illegible]

Communications Plan

The distributed locations of project participants, participating organizations as well as key management support dictates that the PCB explicitly plan, prepare, and distribute timely project communications. In fact, under such circumstances, proper communication planning is a key factor for the overall success of the project.

In order to facilitate communication among all these varied participants, VBA uses a complete set of tools including a VETSNET Web page, Dimensions, Process Max and other common development tools.

Communication Plan

The Communication Plan (CP) establishes the processes, methods, tools and standards to ensure clear and effective communication to all project stakeholders. Official project scope, plans, technical documentation and status information will be managed under this CP.

The CP will describe the "Who", "What", "How" and "How Often" project information will be collected, maintained and distributed to all participant levels. Appropriate detail about "What" may include information regarding:

- Deliverable evaluation
- Collaboration/idea generation
- Issue and Risk resolution
- Project performance assessment
- Funding

Appropriate detail about "How" may include information regarding the use of:

- VEB/ PCB/ CCB/ PT Meetings
- Project Status Reports
- Technical working groups
- Change Control Mechanisms

Appropriate detail about "How Often" may include information regarding:

- Weekly Updates
- Bi-weekly Updates
- Management Reviews

The CP identifies the project member directly responsible for the development and distribution of the appropriate information. The CP includes stakeholder management, project data management and project reports.

Stakeholders and Organization

A stakeholder is anyone positively or negatively impacted by the outcome of the project. This section documents the key stakeholders for this project. The key stakeholder group is organized into units for the purpose of information distribution.

The Project Key Stakeholder Chart is listed below ?????. The chart illustrates how the project's key stakeholders relate to each other for the purpose of this project. This chart displays who is involved in the project and how information should flow.

In addition to the listing of Project Key Stakeholders, a site specific stakeholders listing will be prepared for each individual telephone system ????.effort and provided in the site specific project plan addendum.

Data Sets and Tracking Tools

Project information will be developed, collected, documented, tracked and stored by the PCB with input from the stakeholders. Project information includes the Scope Statement, PMP (i.e., the WBS, Project Schedule, CP, Risk, and Cost Control plans), Issues/Risks logs, contract documentation, reports, minutes, analyses and any and all other data pertinent to the management of the VETSNET Project.

Specified project data will be stored and maintained by the PCB. The primary data tracking and reporting tool is IT Project Office. This application will house all task, schedule, resource and cost data. The VBA PMO will maintain the schedule on a weekly basis with inputs from the VEB, PCB, CCB , and other key stakeholders. The information will be updated in IT Project Office within 1 week from the Project Status meeting.

Reporting Process

Project Reporting is designed to deliver relevant, timely, and targeted project information to stakeholders. It is the goal of the VETSNET project to provide open access, a wide distribution of information, and foster two-way communication at all levels of the organization. The Matrix in Attachment "E" shows the report type, stakeholder group and schedule for each communication deliverable. Each report/presentation deliverable is considered available to all distribution levels higher than the level in which it is specified.

Attachment A – Work Breakdown Structure (WBS)

The official WBS for VETSNET is maintained in Primavera IT Project Office and managed by the PM with support from the VBA PMO. The following narrative is representative of the entire WBS contained in TeamPlay.

The full WBS is accessible via the IT Project Office project web site shown in the addenda.

The project web site is updated weekly.

Attachment B – Schedule

The detailed schedule for the VETSNET Project is maintained in Primavera IT Project Office and managed by the PM with support from the VBA PMO. The following narrative is representative of the entire schedule contained in TeamPlay.

The detailed schedule identifies the activities, activity durations, and resources needed (labor and non-labor as required) to complete the VETSNET Project. The schedule tracks the planned start and end dates and the actual start and end date.

The project web site is updated weekly or at the direction of the PM and PCB.

Milestone	Due Date

Attachment C –Risk Assessment Form for Initiative

Initiative Risks:

The process of identifying, allocating, managing and minimizing risk are crucial to the success of the initiative. The ability of the management team to track and understand various risks and then to allocate resources to mitigate them will be a major factor in bringing the initiative in on time and on budget.

Initiative Risks (Use one form for each risk associated with an initiative)

Risk Number:	Date Raised:	Raised By:	Owner:
Short Title:			
Status: <input type="checkbox"/> Draft <input type="checkbox"/> Open <input type="checkbox"/> Rejected <input type="checkbox"/> Closed		Mail Form to Owner: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Evaluation:			
Containment Strategy:			
Probability: <input type="checkbox"/> High (Very Likely) <input type="checkbox"/> Medium (Probable) <input type="checkbox"/> Low (Possible)		Impact: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	

Attachment D – Change Request Form

(Use one form for each Change associated with a baselined project component)

C1. <u>Date Initiated</u>	C2. <u>Initiator</u>
C3. <u>Requested Implementation Date</u>	C4. <u>Change Priority</u>
C5. <u>Change Title</u>	
C6. <u>Change Description:</u>	
C7. <u>Reason for Change:</u>	
C8. <u>Impact of Change (Project work components affected, individuals or groups affected, Cost and Schedule Impact)</u>	
C9. <u>Change Analysis (to be completed by PT)</u>	
C10. <u>Approval/Disapproval</u>	
PCB Member	Date
PCB Member	Date
PCB Member	Date
C11. <u>Date forwarded to ESC</u>	

Attachment E – Communication Matrix

Category	Communication Item	Description	Purpose	Frequency	Media/Tool	Audience	Responsibility (Owner)
Planning	Project Management Plan (PMP)	The PMP documents the management approach and infrastructure required to successfully control the project.	It is a communication tool for the stakeholders to know what will be done and who is responsible for each work effort.	Once but updated as needed.	Word document via email	PT	PMO
Execution	PCB Feedback	PCB shares new information. The PCB Chair emails or calls PT to share information.	Distribute relevant information to PT.	As Needed	Email or Conference Call	PT	PCB Chair
Execution	VEB Feedback	VEB contacts PM with new information. Then PM emails or calls PT to share information.	Distribute relevant information to PT.	As Needed	Email or Conference Call	PM	VEB
Control	Risk Log	Risk ID, creation date, description, person responsible, status, and status date. They will be reviewed in the status meetings and managed using TeamPlay.	Identify and monitor risk events that may impact the project. If they occur, implement corrective action.	Weekly during project meetings	Paper and electronic entry to status system, TeamPlay	PT	PMO
Control	Action Item Log	Action Item ID, creation date, description, person responsible, status, and status date. They will be reviewed in the status meetings.	Issues are concerns that unexpectedly occur during the project and need to be discussed or clarified to resolve. This log will manage that process.	Weekly during project meetings	Paper and electronic entry to status system, TeamPlay	PT	PMO
Control	PT Status Conference Call Agenda	Outline of what will be covered during the Status Conference Call.	Ensure that all areas that need to be discussed are on the agenda. Also, that each person is prepared to discuss the agenda item.	As Needed	Word document distributed via email.	PT	PM
Control	PT Status Conference Calls	Review accomplishments since last meeting, risks/issues, and overall status for the project.	Communicate areas of importance and concern among the PT.	As Needed	Conference call	PT	PM
Control	Project Status Conference Call Minutes	Attendees, agenda, areas/presentations, persons responsible for presentations, action items, next meeting	Informational < For records and those who are not in attendance.	Following Conference Call	Word document	PM, PT	PT Member

Category	Communication Item	Description	Purpose	Frequency	Media/Tool	Audience	Responsibility (Owner)
Control	Project Website	The website will contain project information including schedule, risks, reports and documents.	Central repository for all project information.	Updated Weekly by Friday morning.	TeamPlay via HTML	Everyone	PMO
Control	Master Schedule Report	Report of entire project schedule. Found on the project website.	Reviewed to ensure that there are no issues with the schedule.	Updated Weekly by Friday morning.	Project Website	Everyone	PMO
Control	2 Week Look-ahead report	Snapshot of schedule for the next 2 weeks. Found on the Project Website.	Reviewed during weekly conference call to ensure that there are no issues with the schedule.	Updated Weekly by Friday morning.	Project Website	Everyone	PMO
Control	Ad Hoc Requests	Unique request for assistance from the PT including changes to the project and items needing immediate decisions.	Obtain support for project decisions.	As Needed	Request sent via letter and then discussed via conference call.	Stakeholders	PM
Close-out	Lessons Learned	Brainstorming session that documents what went well and what could be improved regarding this project.	Used as a tool to promote continuous improvement for future project planning.	Once	Word document via email	PT	PM
Control	Risk Log	Risk ID, creation date, description, person responsible, status, and status date. They will be reviewed in the status meetings and managed using TeamPlay.	Identify and monitor risk events that may impact the project. If they occur, implement corrective action.	Weekly during project meetings	Paper and electronic entry to status system, TeamPlay	PT	PMO

Concurrence

Marie S. Causley
Director, VBA Project Management Office

Date

Review

K. Adair Martinez
Deputy Chief Information Officer for Benefits

Date

Review

TBD

Date

Additional Review as required

**Questions for the Record
Honorable Lane Evans
Committee on Veterans' Affairs
February 16, 2005
Hearing on Department of
Veterans Affairs
Fiscal Year 2006 Budget**

Question 26- Attachment

Spreadsheet titled:

VA Health Care Enrollees and
Expenditures for U.S. & Puerto Rico for
FY 2004.

VA HEALTH CARE ENROLLEES AND EXPENDITURES FOR U.S. & PUERTO RICO FOR FY 2004
Expenditures in \$000

STATE	VA MEDICAL CARE - FY 2004	
	Health Care	Medical
	Enrollees	Expenditures
TOTALS	7,392,748	\$27,361,068
Alabama	137,331	481,255
Alaska	23,431	103,238
Arizona	168,064	578,819
Arkansas	108,958	486,851
California	609,588	2,510,044
Colorado	97,557	340,956
Connecticut	77,386	271,004
Delaware	21,174	71,228
District of Columbia	16,424	116,017
Florida	604,199	1,991,144
Georgia	199,158	667,857
Hawaii	31,434	112,711
Idaho	41,852	146,598
Illinois	275,109	1,056,293
Indiana	152,681	515,465
Iowa	89,257	293,009
Kansas	79,148	269,363
Kentucky	121,898	461,927
Louisiana	125,081	484,258
Maine	47,530	181,363
Maryland	119,928	501,802
Massachusetts	130,787	609,501
Michigan	169,556	668,813
Minnesota	118,587	469,415
Mississippi	92,546	407,385
Missouri	167,052	637,741
Montana	38,631	120,710
Nebraska	57,303	244,190
Nevada	78,936	293,112
New Hampshire	35,295	138,959
New Jersey	154,031	453,522
New Mexico	63,292	247,062
New York	459,993	1,707,981
North Carolina	220,444	731,081
North Dakota	24,215	62,830

VA HEALTH CARE ENROLLEES AND EXPENDITURES FOR U.S. & PUERTO RICO FOR FY 2004
Expenditures in \$000

STATE	VA MEDICAL CARE - FY 2004	
	Health Care Enrollees	Medical Expenditures
Ohio	286,085	998,489
Oklahoma	113,479	410,823
Oregon	106,446	434,928
Pennsylvania	348,670	1,130,967
Rhode Island	27,055	113,291
South Carolina	131,423	442,920
South Dakota	36,937	161,593
Tennessee	153,003	598,196
Texas	522,726	1,897,771
Utah	41,653	175,276
Vermont	19,637	68,174
Virginia	178,227	643,952
Washington	148,430	543,489
West Virginia	82,681	346,176
Wisconsin	134,614	525,605
Wyoming	22,745	97,773
Puerto Rico	81,081	338,135

Notes:

Health Care enrollees are shown by home residence. Data is unrounded.

The data does not include Philippines, Guam, Samoa, the Virgin Islands, and other foreign countries so therefore will not add up to the totals provided for the VA FY 2006 budget document.

Medical expenditures represent cost assigned to each patient based on services provided and overhead distribution.

Not included in medical expenditures are: Research, General Post Fund, Canteen Service, and certain other expenditures that total approximately \$772.4 million.

**Questions for the Record
Honorable Stephanie Herseth
Committee on Veterans' Affairs
February 16, 2005**

Hearing on VA FY 2006 Budget

Question 1: In the area of veterans' education benefits, the President's budget request would eliminate 14 full-time staff positions within the VA's Education Service. How do you justify this request?

As you know, education claims are expected to increase due to more veterans seeking to take advantage of the Montgomery GI Bill, as well as the new Chapter 1607 – Guard and Reserve program enacted last year as part of the National Defense Authorization Act of 2005 (section 527 of the National Defense Authorization Act of 2005; Public Law 108-375).

Response: VBA believes it can satisfy the increase in education claims by managing where the staff reductions occur and using targeted overtime during peak periods. VBA does foresee a slight increase in the average number of days to process original claims. The budget submission reflects a two day increase in processing time. However, VBA will maintain the 2005 performance levels for all other measures in 2006.

Question 2: Recognizing the great importance of providing quality employment services to our transitioning disabled service members, former Secretary Anthony J. Principi, established a task force to review the vocational rehabilitation and employment program (VR&E) from "top-to-bottom". The VR&E Task Force issued a comprehensive report in May of 2004. The report contained 102 recommendations to improve the VR&E program and reform it to be responsive to 21st Century needs of service-connected disabled veterans.

The Task Force recommended an additional 228 full-time staff positions for the VR&E program: including 27 FTEE in headquarters; 112 in the regional offices to deliver direct services; 56 in the regional offices for contracting and purchasing; and 8 quality assurance staff.

The President's budget request does not provide any resources consistent with the VA's own VR&E Task Force report. Rather, the President's budget simply reflects a redistribution of "management support" personnel.

Please provide the Administration's short term and long term plans to provide these necessary resources to the VR&E program.

Response: The fiscal year (FY) 2005 full time employee (FTE) level for direct service delivery in the vocational rehabilitation and education (VR&E) program was increased by 87 FTE over the FY 2005 budget estimate to support implementation of the task force recommendations. This increased FTE level is

sustained in the FY 2006 budget request. Additionally, the FY 2006 budget includes an increase of 21 FTE in VR&E for management direction and support.

The VR&E service restructured its headquarters operations and redirected eight FTE to the VR&E quality assurance team. The service also filled a contracting specialist position to oversee and advise field staff on the contracting efforts of the VR&E divisions nationwide.

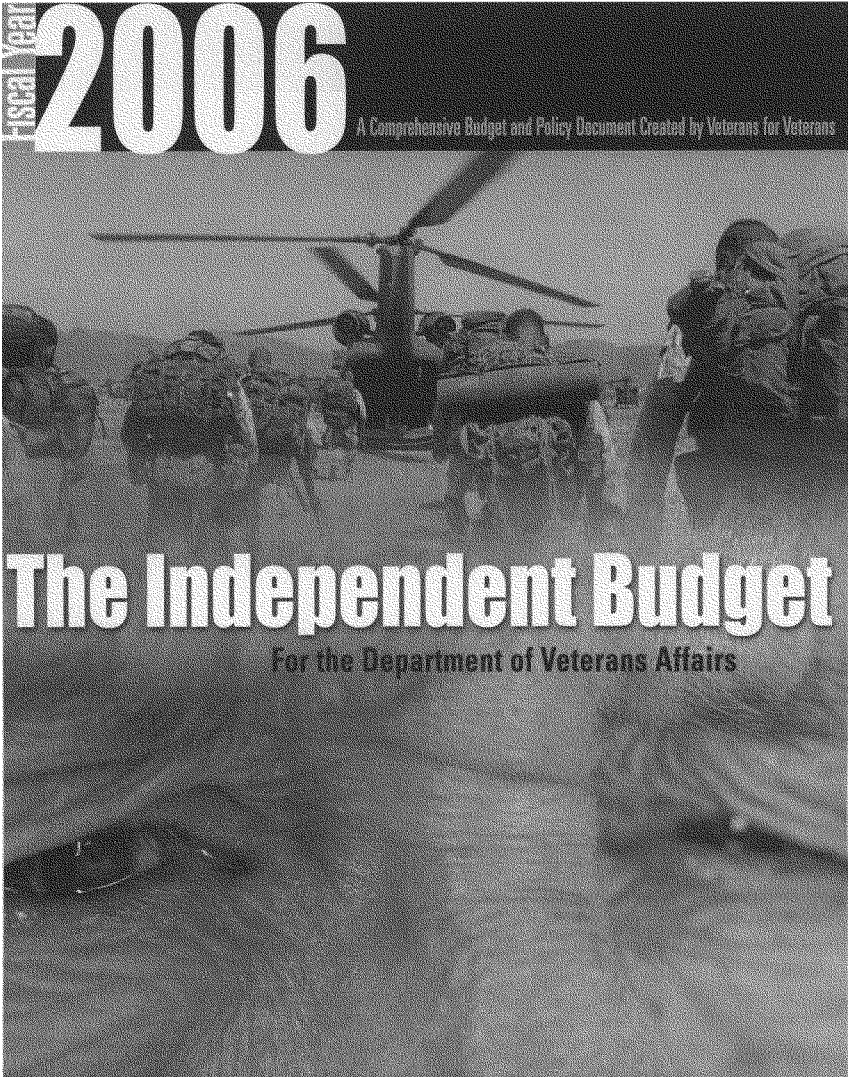
Although VBA has not staffed the field offices to support full-time contract specialists, at least one employee in each VR&E division nationwide has completed the training necessary to qualify for a contracting warrant. VBA is also scheduling a training session with the field VR&E officers to emphasize the importance of overseeing and monitoring contracts.

The VR&E service is continuing to implement the task force recommendations, including the five-track employment model, job labs, disabled transition assistance program briefings, and other outreach efforts; and enhanced corporate WINRS, VBA's information and case management system. The FY 2006 process improvements initiative provides \$4.35 million for the five-track employment model, including the establishment of job labs and an aggressive program of marketing to potential employers.

	E-4 with 2 years Service VA Care		E-7 with 20 years Service DoD TRICARE			
	Current		Prime	Extra	Standard	
Under AGE 65	Annual Enrollment Fee	\$0.00	Annual Enrollment Fee	\$230.00	\$0.00	\$0.00
			Annual Deductible	\$0.00	\$150.00	\$150.00
	Preventive Care Copay	\$0.00	Military Hospital Copay	\$0.00	\$0.00	\$0.00
					20% of negotiated fee	25% of allowed charges
	Primary Care Copay	\$15.00	Civilian Copays			
	Specialty Care Copay	\$50.00	Civilian Outpt Visit	\$12.00		
	Emergency Room Copay	\$0.00	Civilian Emergency Room	\$30.00		
	Mental Health Copay	\$0.00	Civilian Mental Health	\$25.00		
	Pharmacy Copay	\$7.00	Pharmacy Military Hospital			
			Tier 1 Generic	\$0.00	\$0.00	\$0.00
			Tier 2 Formulary	\$0.00	\$0.00	\$0.00
			Tier 3 Non-Formulary	N/A	N/A	N/A
			Pharmacy Mail Order (90 day RX)			
			Tier 1 Generic	\$3.00	\$3.00	\$3.00
Over AGE 65	Proposed		Tier 2 Formulary	\$9.00	\$9.00	\$9.00
	Annual Enrollment Fee	\$250.00	Tier 3 Non-Formulary	\$22.00	\$22.00	\$22.00
	Preventive Care Copay	\$0.00	Pharmacy Retail (30 day RX)			
	Primary Care Copay	\$15.00	Tier 1 Generic	\$3.00	\$3.00	\$3.00
	Specialty Care Copay	\$50.00	Tier 2 Formulary	\$9.00	\$9.00	\$9.00
	Emergency Room Copay	\$0.00	Tier 3 Non-Formulary	\$22.00	\$22.00	\$22.00
	Mental Health Copay	\$0.00				
	Pharmacy Copay	\$15.00				
			TRICARE for Life (TFL) Replaces Prime, Extra, & Standard			
		Same as Under Age 65 for VA Care	Part B Medicare Premium			
			(\$78.20 per month)			
			TRICARE for Life pays Medicare deductibles and copays			

Prepared by the Democratic Staff of the Committee on Veterans Affairs
February 15, 2005

Appropriation/Fund Account (in millions)	2005	2006	Difference 2006-2005	% Difference 2006-2005	2006 IB	2006 IB minus 2006
Benefit programs:						
Disability Compensation	28,960	29,772	812	2.80%		
Pensions	3,294	3,470	176	5.34%		
Education	2,172	2,580	408	18.78%		
Vocational rehabilitation and employment	569	634	65	11.42%		
Insurance	44	48	2	4.55%		
Housing Program Account	1,904	65	-1,839	-96.59%		
Burial	169	171	2	1.18%		
Total Benefits Mandatory	37,112	36,738	-374	-1.01%		
Total Benefits Administration	1,448	1,406	-42	-2.90%	1,367	-39
TOTAL BENEFITS (does not include construction)	38,560	38,144	-416	-1.08%		
Medical programs:						
Medical services	19,902	19,952	50	0.25%	22,486	2,534
Medical care collection fund	1,953	2,588	635	32.51%		
Medical administration	4,437	4,517	80	1.80%	4,866	349
Medical facilities	3,330	3,298	-32	-0.96%	3,875	577
VADoD Health Sharing Incentive Fund	30	43	13	43.33%	0	-43
Medical and prosthetic research	402	393	-9	-2.24%	460	67
Total medical programs	30,054	30,791	737	2.45%	31,687	896
Total medical programs without collections	28,101	28,203	102	0.36%	31,687	3,484
Department Administration:						
Construction						
Major and Minor Construction	700	816	116	16.57%	1,283	467
Grants for Construction of State Extended Care Facilities	104	0	-104	-100.00%	150	150
Grants for the Construction of State Veterans Cemeteries	32	32	0	0.00%	37	5
Total Construction	836	848	12	1.44%	1,470	622
Total General Administration	295	325	30	10.17%	388	63
Total Office of Inspector General	69	70	1	1.45%	71	1
Total appropriations	69,814	70,178	364	0.52%		
Total Mandatory	37,112	36,738	-374	-1.01%		
Total Discretionary without MCCF	30,749	30,852	103	0.33%		
Total Discretionary with MCCF and other receipts	32,702	33,440	738	2.26%	34,983	1,543



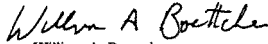
Prologue

This is the 19th year *The Independent Budget* has been developed by four veterans service organizations (VSOs): AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States. This document is the collaborative effort of a united veteran and health advocacy community that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs (VA) and the Department of Labor.

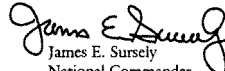
The Independent Budget is built on a systematic methodology that takes into account changes in the size and age structure of the veteran population, federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans to be laid to rest in our national and state veterans cemeteries.

As in years past, the budget and appropriations for veterans programs for fiscal year 2006 will line up as discretionary spending in tortured competition with all other domestic discretionary programs funded by the Federal Government. *The Independent Budget* VSOs have become increasingly alarmed that this annual battle for funding is failing to meet the true needs of the veteran population. Dollar amounts are never adequate in the push and pull of the congressional process. Furthermore, judging from the experiences of the past 3 years alone, Congress has failed to even pass a VA appropriations bill until months into the new fiscal year, leaving VA hospitals limping along on wholly inadequate continuing resolutions. The system does not suffer in this process, veterans do, veterans waiting months for a doctor's appointment or hours for a nurse to answer a call button.

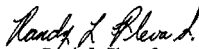
This year, as in the past, we call on Congress to find a better way to fund veterans health-care spending by removing the veterans budget from the battle over annual discretionary spending. We call on Congress to establish a formula to provide VA health-care funding from the mandatory side of the Federal budget, assuring an adequate and timely flow of dollars to meet the needs of sick and disabled veterans.



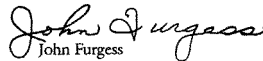
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FY 2006 INDEPENDENT BUDGET SUPPORTERS

Administrators of Internal Medicine (AIM)
 Alliance for Academic Internal Medicine (AAIM)
 Alliance for Aging Research
 American Federation of Government Employees, AFL-CIO (AFGE)
 American Military Retirees Association, Inc. (AMRA)
 American Thoracic Society
 Association of American Medical Colleges
 Association of Program Directors in Internal Medicine (APDIM)
 Association of Subspecialty Professors (ASP)
 Blinded Veterans Association (BVA)
 Blue Star Mothers of America, Inc.
 Catholic War Veterans, USA
 Christopher Reeve Paralysis Foundation
 Clerkship Directors in Internal Medicine
 Gold Star Wives of America, Inc.
 Military Officers Association of America (MOAA)
 National Association of County Veterans Service Officers (NAVCO)
 National Association for Uniformed Services (NAUS)
 National Association of State Veteran Homes
 National Association of Veterans' Research and Education Foundations (NAVREF)
 National Mental Health Association
 National Military Family Association (NMFA)
 National Spinal Cord Injury Association (NSCIA)
 Non Commissioned Officers Association of the USA (NCOA)
 Rhode Island Veterans Action Center
 Veterans Affairs Physician Assistant Association (VAPAA)
 Veterans of the Vietnam War, Inc. and the Veterans Coalition

Guiding Principles

- ▼ Veterans must not have to wait for benefits to which they are entitled.
- ▼ Veterans must be ensured access to high-quality medical care.
- ▼ Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- ▼ Veterans must be assured burial in state or national cemeteries in every state.
- ▼ Specialized care must remain the focus of the Department of Veterans Affairs (VA).
- ▼ VA's mission to support the military medical system in time of war or national emergency is essential to the nation's security.
- ▼ VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans health-care system and to the advancement of American medicine.
- ▼ VA's mission to support health professional education is vital to the health of all Americans.

ACKNOWLEDGEMENTS

We would like to thank the staff from the four *Independent Budget* veterans service organizations for their contributions in creating this document. We especially thank Steering Committee members Rick Jones, AMVETS (FY 2006 chairman); Joseph Violante, DAV; Richard Fuller, PVA; and William Bradshaw, VFW, for their guidance on and review of the document.

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Introduction

For the 19th year, *The Independent Budget* veterans service organizations (IBVSOs) face the task of assessing the medical care needs of veterans for the upcoming fiscal year and providing best estimates on the resources necessary to carry out a responsible budget at the Department of Veterans Affairs (VA). We are proud that 26 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans in 2006.

As the global war on terrorism wages on, with many troops overseas and heightened security measures at home, it is important that the needs of our sons and daughters returning home from the battlefield are fully met. It is time to recognize the VA health-care and benefits system for what it is—a critical national resource for our nation's increasing veteran population. Veterans depend on VA for the health-care, housing, education, vocational rehabilitation, and insurance benefits they earned serving our country. This year more than ever VA is once again faced with the challenges of skyrocketing health-care costs, increasing demand for services, and eroding value of benefits. As the Administration and Congress consider the monetary needs of VA this fiscal year, they should pause to consider how much is at stake.

Each year, the IBVSOs call on Congress for sufficient funding for VA health care and a budget that reflects the increasing need for medical services. But year after year, VA remains underfunded and unable to provide timely access to quality health care to many of our nation's veterans. The annual budget crisis only adds to the struggle veterans face in obtaining timely and quality care. That is why *The Independent Budget (IB)* again recommends Congress take action to enact legislation providing adequate mandatory funding for the VA health-care system. Mandatory funding would ensure that the government meets its obligation to ensure all veterans eligible for VA health care have access to timely, quality care. Until mandatory funding becomes a reality, it is vital that the VA health-care system receive the resources it needs through the annual appropriations process, and that this funding be provided at the start of the fiscal year—not delayed for months, a situation that has become far too common.

As the largest federal provider of health-care services, VA is also faced with operating and maintaining thousands of medical facilities, centers, clinics, and nursing homes. This year's *IB* recommends a sizable increase for major and minor construction to help eliminate backlogs caused by the moratorium on facility improvement provided for in the Capital Asset Realignment for Enhanced Services (CARES) process. Also, with the loss of increasing numbers of our senior veterans, we call for major expansion and improvements in the VA cemetery program. Currently, the National Cemetery Administration (NCA) maintains more than 2.6 million gravesites on approximately 14,000 acres of cemetery land, while providing

nearly 90,000 interments annually. The NCA requires increases in funding if it is to carry out its statutory mandates. Without the firm commitment of Congress and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

On the benefits side, the *IB* continues to be concerned over the backlog in claims processing. According to the Government Accountability Office, the Veterans Benefits Administration still faces problems with large backlogs and long waits for decisions, despite years of studying these problems and the determination that the primary cause is directly attributed to the massive full-time employee equivalent reductions imposed on the Veterans Benefits Administration from fiscal years 1992 through 1998. Nearly one-third of adjudication decisions are incorrect or have technical or procedural

errors. The IBVSOs reiterate our concern over the shrinking value of benefits that continue to decline in value because of a lack of increases, in some cases, for years. Veterans' benefits are part of a covenant between our nation and its defenders and should never be denied, reduced, or delayed.

The Independent Budget covers the broadest spectrum of veterans' benefits and services with recommendations on each to make certain we keep the nation's obligation to those who have served and sacrificed in its defense. The *IB* recognizes that veterans' health care and benefits cost money, but these men and women have paid the price. They have taken the oath. They have served our country honorably and admirably. Promises were made to them, and we have an obligation to keep those promises.

Department of Veterans Affairs
(Discretionary Budget Authority)
(Dollars in Thousands)

	FY 2005 Appropriation	FY 2006 Administration Request	FY 2006 IB Recommended Appropriation
Medical Services	\$19,316,995	\$19,995,141	\$22,486,154
Medical Administration	4,667,360	4,517,874	4,866,036
Medical Facilities	3,715,040	3,297,669	3,874,808
Total, Medical Care	27,699,395	27,810,684	31,226,998
Medical and Prosthetic Research	402,348	393,000	460,000
Subtotal, Veterans Health Administration	28,101,743	28,203,684	31,686,998
Veterans Benefits Administration	1,027,193	1,082,976	1,162,500
General Administration	297,560	324,889	388,035
Total, General Operating Expenses (GOE)	1,324,753	1,407,865	1,550,535
National Cemetery Administration	147,734	167,409	204,046
Office of Inspector General	69,153	70,174	71,383
Subtotal, Department Administration and Miscellaneous Programs	1,541,640	1,645,448	1,825,964
Construction, Major	455,130	607,100	562,800
Construction, Minor	228,933	208,726	720,000
Grants for State Extended Care Facilities	104,322	—	150,000
Grants for Construction of State Veterans Cemeteries	31,744	32,000	37,000
Subtotal, Construction Programs	820,129	847,826	1,469,800
Total, Discretionary	\$30,463,512	\$30,696,958	\$34,982,762

Benefits Programs

Ours is a nation that holds a special appreciation and high regard for those who have served in our armed forces. Ours is a nation that recognizes a profound indebtedness to those who have borne extraordinary burdens and made extraordinary sacrifices to defend our national interests. Through our government, we therefore provide special assistance to veterans and their dependents to fulfill our nation's obligation to make up for the effects of disadvantages from disabilities incurred in connection with military service and education and employment opportunities forgone or lost during service in our armed forces.

For budgetary classification, the benefit programs are grouped into three major categories:

- (1) compensation and pensions, which also includes the appropriations for burial benefits, miscellaneous assistance, and special benefits for children of Vietnam veterans;
- (2) readjustment benefits, which includes specially adapted housing grants, vocational rehabilitation programs, educational benefits, housing loans, and automobiles and adaptive equipment; and
- (3) insurance programs.

Disability compensation payments fulfill our primary obligation to make up for the economic and other losses veterans suffer due to the effects of service-connected diseases and injuries. When veterans' lives are cut short due to service-connected causes or following a substantial period of total service-connected disability, eligible family members receive dependency and indemnity compensation (DIC). Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes or who have attained age 65. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of these veterans, Congress authorized special programs to provide a monthly monetary allowance, medical treatment, and vocation rehabilitation to these children.

In recognition of the disadvantages that result from interruption of civilian life to perform military service, Congress has authorized various benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide monetary assistance to veterans undertaking education or vocational rehabilitation programs and to seriously disabled veterans in acquiring specially adapted housing and automobiles. Educational benefits are also available

BENEFITS PROGRAMS

for children and spouses of veterans who are permanently and totally disabled or die as a result of service-connected disability. Qualifying students pursuing Department of Veterans Affairs (VA) education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

The Post-Vietnam Era Veterans Education Program provides educational assistance to veterans who entered service between December 31, 1976, and July 1, 1985. This assistance is funded by the contributions participating veterans made during their service and matching funds from the Department of Defense.

Under its home loan program, VA guarantees home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible reservists and National Guard personnel. VA also makes direct loans to supplement specially adapted housing grants. Under a program authorized until December 31, 2008, VA makes direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserves. A group plan also covers service members and members of the Ready Reserves and their family members. Mortgage life insurance protects veterans who have received specially adapted housing grants.

Through collaborative efforts of Congress, VA, and veterans organizations, these benefit programs have been carefully crafted. Experience has proven that they generally serve their intended purposes and taxpayers very well. Over time, however, we learn of areas in which adjustments are needed to make the programs better serve veterans or to meet changing circumstances. Unfortunately, failure to regularly adjust the benefit rates for increases in the cost of living and failure to make other needed changes threatens the effectiveness of some veterans benefits.

Veterans' programs must remain a national priority. Additionally, they must be maintained, protected, and improved as necessary. To maintain or increase their effectiveness, we offer the following recommendations.



Benefits Issues

COMPENSATION AND PENSIONS

Compensation

Annual Cost-of-Living Adjustment:

Congress should provide a cost-of-living adjustment (COLA) for compensation benefits.

Veterans whose earning power is limited or completely lost due to service-connected disabilities must rely on compensation for the necessities of life. Similarly, surviving spouses of veterans who died of service-connected disabilities often have little or no income other than dependency and indemnity compensation (DIC). Compensation and DIC rates are modest, and any erosion due to inflation has a direct detrimental impact on recipients with fixed incomes. Therefore,

these benefits must be adjusted periodically to keep pace with increases in the cost of living. Observant of this principle, Congress has traditionally adjusted compensation and DIC rates annually.

Recommendation:

Congress should enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.



Full Cost-of-Living Adjustment for Compensation:

To maintain the effectiveness of compensation for offsetting the economic loss resulting from service-connected disability and death, Congress must provide cost-of-living adjustments (COLAs) equal to the annual increase in the cost of living.

Disability and dependency and indemnity compensation rates have historically been increased each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the federal budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break the habit of extending this round-down provision and has extended it even in the face of budget surpluses. Inexplicably, VA budgets have recommended that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for one or two years

may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended—and certainly permanent—rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and dependents, who must rely on their modest compensation for the necessities of life.

Recommendation:

Congress should reject administration recommendations to permanently extend provisions for rounding down compensation COLAs and allow the temporary round-down provisions to expire on their statutory sunset date.

Standard for Service Connection:*Service-connected benefits should be provided for all disabilities incurred or aggravated in the line of duty.*

The core veterans' benefits are those provided to make up for the effects of "service-connected" disabilities and deaths. When disability or death results from an injury or disease incurred or aggravated in the "line of duty," the disability or death is service-connected for purposes of entitlement to these benefits for veterans and their eligible dependents and survivors. A disability or death from injury or disease is in the line of duty if incurred or aggravated "during" active military, naval, or air service, unless due to misconduct or other disqualifying circumstances. Accordingly, a disability or death from an injury or disease that occurs or increases during service meets the current requirements of law for service connection.

These principles are expressly and clearly set forth in current law. Under the law, the term "service connected" means, with respect to disability or death, "that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." The term "active military, naval, or air service," contemplates, principally, "active duty," although duty for training qualifies when a disability is incurred during such period. The term "active duty" means "full-time" duty in the armed forces.

A member on active duty in the armed forces is at the disposal of military authority and, in effect, on duty 24 hours a day, 7 days a week. Under many circumstances, such member may be directly engaged in performing tasks involved in his or her military vocation for far more extended periods than a typical eight-hour civilian workday and may be on call or standing by for the remainder of the hours in a day. Under other typical circumstances, a service member may live on or near the workstation 24 hours a day, such as is the case with duty on submarine, ship, or remote outpost. Even when a military member is not actively or directly engaged in performing functions of his or her military occupation, the member is indirectly on duty or involved in general military duties and ongoing responsibilities. In the military service, there is no distinction between on duty and off duty for purposes of legal status, and there is often no clear practical demarcation between being on and being off duty. Moreover, in the overall military environment, there

are rigors, physical and mental stresses, and known and unknown risks and hazards unlike, and far beyond, those seen in civilian occupations and daily life. Military members stationed in foreign countries are often exposed to increased risks of injury and disease, both on and off military facilities.

For these reasons, current law requires only that an injury or disease be incurred or aggravated "coincident with" military service; there is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought. For these same reasons, a requirement to prove service causation would be unworkable as long as it is the purpose of the law to equitably dispose of questions of service connection and provide benefits when benefits are rightfully due those who lay their health and lives on the line to bear the extraordinary burdens of defending our national interests. Of course, if it were to become the object of our government to limit as much as possible its responsibility for veterans' disabilities rather than to have a fair and practical legal framework for justice, requiring proof of service causation would accomplish that object quite effectively by making it impossible to prove many meritorious claims.

Surprisingly, during deliberations on the annual defense authorization bill for fiscal year 2004, key members of the leadership of the United States House of Representatives developed a scheme to accomplish that very purpose by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be in order unless a veteran could prove that a disability was caused by actually performing military duties per se. Although this scheme was not enacted into law, the defense authorization bill did provide for the establishment of a commission to study the foundations of disability benefit programs for veterans, presumably with the same ultimate goal in mind. This action is consistent with current systematic efforts to reduce spending on military personnel and veterans to devote more resources to military hardware and the other costs of war.

It is self-evident that current standards governing service-connected status for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. *The Independent Budget* veterans service organizations urge Congress to reject any revision of this standard for the purpose of permitting the government to coldly and expediently avoid its responsibilities for the human costs of war and national defense.

Recommendation:

Congress should reject any suggestion to change the terms for service connection of disabilities and deaths.



Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and Department of Veterans Affairs (VA) disability compensation concurrently.

Some former service members who are retired from the armed forces on the basis of length of service must forfeit a portion of the retired pay they earned through faithful performance of military service to receive compensation for service-connected disabilities. This is inequitable because military retired pay is earned by virtue of a veteran's long service on behalf of the country.

Entitlement to compensation, on the other hand, is for an entirely separate reason—because of service-related disability. Many nondisabled military retirees pursue second careers after service to supplement their income, thereby justly enjoying the full reward for completion of a military career along with the added reward of full pay for the civilian employment. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability. To put them on equal footing with nondisabled retirees, they should receive full military retired pay and compensation to substitute for diminution of earning capacity.

To the extent that military retired pay and disability compensation now offset each other, the disabled

retiree is treated less fairly than the nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after his or her enlistment expires can receive full compensation and full civilian retired pay. A veteran who has served this country for 20 years or more should have that same right. The veteran should not be penalized for choosing the military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Compensation should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of compensation the veteran receives, our government is in effect paying the veteran nothing for the service-connected disability he or she suffers. *The Independent Budget* veterans service organizations urge Congress to correct this serious inequity.

Recommendation:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their VA disability compensation.

Continuation of Monthly Payments for all Compensable Service-Connected Disabilities:

Lump-sum settlements of disability compensation should not be used as a way to decrease the government's obligation to disabled veterans and save the government money.

Under current law, the government pays disability compensation monthly to eligible veterans on account of and at a rate commensurate with diminished earning capacity resulting from the effects of service-connected diseases and injuries. By design, compensation continues to provide relief from the service-connected disability for as long as the veteran continues to suffer its effects at a compensable level. By law, the level of disability determines the rate of compensation, thereby requiring reevaluation of the disability upon change in its degree. Lump-sum payments have been recommended as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to service-connected disabled veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, the

Department of Veterans Affairs (VA) would use the immediate availability of a lump-sum settlement to entice veterans to bargain away their future entitlement. Such lump-sum payments would not, on the whole, be in the best interests of disabled veterans, but rather would be for government savings and convenience. *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

Congress should reject any recommendation that it change the law to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.



Exclusion of Compensation as Countable Income for Federal Programs:

Disability compensation should not be counted as income for purposes of eligibility for assisted housing through the Department of Housing and Urban Development (HUD) and other means-tested federal programs.

Current policy at HUD considers nontaxable service-connected disability compensation provided by VA to be countable income when determining a veteran's eligibility for HUD's Assisted Senior Housing Program. In some cases, particularly when income is limited to Social Security and Department of Veterans Affairs (VA) disability compensation, our aging veterans are being denied access to this program because their VA compensation places them above an established income threshold. This compassionate program

must be available to those veterans who have severely limited incomes. The principle that disability compensation should not be counted as income should extend to all federal programs.

Recommendation:

Congress should enact legislation to exempt VA disability compensation from countable income for purposes eligibility for federally funded programs.



Service Connection for Smoking-Related Disabilities:

Congress should reverse its action that took money from veterans' disability compensation to pay for over-budget spending on transportation programs.

In 1998 Congress changed the law to prohibit service connection for disabilities related to smoking. Under the pretext of making an appropriate change in law for genuine public policy purposes, Congress enacted, in a transportation bill, a provision concocted to generate savings from the veterans' disability compensation program to pay for over-budget spending on politically popular transportation programs. This unprecedented raid on veterans' programs for the ignoble purpose of paying the cost of massive pork-barrel spending was a shameful injustice against veterans. At a cost of \$217 billion, this transportation bill contained nearly 1,500 pork projects and exceeded by \$26 billion the spending caps set in the balanced budget bill of the year before.

Compensation for smoking-related disabilities provided a convenient target for those with the motive of finding money to satisfy their appetite for big spending. The target was convenient because it was easy to get similarly inclined members to subscribe to the superficial arguments that veterans should not be compensated for disabilities that result from their personal choice to use an injurious product. It was made an attractive target for those who coveted the money for their own use by exaggeration of the costs of smoking-related compensation for the calculated purpose of artificially increasing the amount of spoils it would yield to those who would capture it as their prize. As a result, they obtained \$15.5 billion to pay for increased spending of massive proportions on transportation programs

It is easy to subscribe to the notion that veterans should not be compensated for illnesses that result from their personal choice to smoke cigarettes. However, the argument that this is merely a matter of personal choice or responsibility is more than a deceptive oversimplification: It is a misrepresentation. The question of whether these are disabilities that should be compensated cannot be answered so simply. Indeed, when the question is considered in the depth required to arrive at a fair, judicious conclusion, the injustice of the prohibition against service connection is easily seen.

Cigarettes have been one of our country's major mass-marketed products since the 1920s. Citizens across all socioeconomic levels have used tobacco for pleasure or have been enticed by its glamorization and romanticization in books, motion pictures, advertising, and in our society in general. Only recently has there been a serious shift in public attitude about smoking and serious proposals to regulate tobacco for public health reasons.

Smoking has traditionally been even more prevalent among members of our armed forces. The Department of Defense (DOD) has been perhaps our nation's largest distributor of cigarettes. The DOD has long been in the business of discounting tobacco products and subsidizing smoking among service members. In past years, many images of soldiers included cigarettes dangling from their mouths. Cigarettes were an integral part of military life. Survey data compiled in connection with a study for Department of Veterans Affairs (VA) showed that more than 70 percent of veterans, as compared to about 50 percent of the U.S. adult population, had a history of smoking. Findings from that study indicate that a significant proportion of veterans started smoking while on active duty. The higher incidence of smoking among veterans can be explained by a military environment and culture that encouraged and facilitated smoking.

Smoking was much more of a social activity in the military setting than it was in civilian life. Part of that was due to the inherent nature of the military environment, and part was due to the military's own use of tobacco as a small and relatively inexpensive but effective way to help service members cope with that difficult environment.

During rigorous training and combat operations, smoking often provided the only opportunity for a brief distraction or escape from the stresses or drudgery of the moment. Smoking provided the only coping tool immediately accessible. Drill instructors and others in control of military units used smoking as the activity for occupying service members during breaks. Servicemembers looked forward to those breaks as their only respite and pause from combat and the

rigors of military training and duties. Smoking was also an ever-present part of the restricted social activities available to service members in isolated military settings.

Perhaps it was for these reasons that the military establishment became a partner with the tobacco companies in distributing cigarettes and promoting tobacco use among members of the military services. It is well established that the armed forces, under various legal authorities, provided rations of tobacco to service members. Free cigarettes were provided to them during combat tours. Free cigarettes were included in C-rations, and, as noted, cigarettes were provided at substantially discounted prices in military exchanges. Thus, we can accurately state that smoking was not only fully approved of by the armed services, it was encouraged and facilitated by the military on a level probably unparalleled anywhere else in our society.

Like the recent groundswell of anti-tobacco sentiments, the government's opposition to tobacco-related benefits for veterans is of recent advent and, within VA, represents an abrupt—and convenient—reversal of policy. Given the government's complicity in tobacco use among veterans, VA's self-righteous hypocrisy and the government's ulterior motive for enacting this legislation become all the more reprehensible.

Under the law, service connection is awarded for any disability incident to service. Disabilities due to willful misconduct are an exception to that rule, however. "Willful misconduct" is "an act involving conscious wrongdoing or known prohibited action." It means a deliberate or intentional act with "knowledge of or wanton and reckless disregard" of its probable consequences. Tobacco use has never been a prohibited action. On the contrary, as noted previously, tobacco use was fully authorized and approved by the military. VA has held expressly that tobacco use is not willful misconduct. In 1964, Administrator's Decision No. 988 pointed out that smoking is not deemed willful misconduct by VA. The Omnibus Reconciliation Act of 1990 amended sections 105(a), 1110, and 1131 of title 38, United States Code, to include "abuse of alcohol or drugs" as disabilities for which service connection is barred. However, smoking did not fall within the definition of drug abuse for VA purposes. In that application, "drug abuse" means use of illegal

drugs, use of illegally or illicitly obtained prescription drugs, intentional use of prescription or nonprescription drugs for purposes other than their medically intended use, and use of substances to enjoy their intoxicating effects.

It would be the height of hypocrisy for Congress or VA to declare smoking misconduct when VA provided free tobacco to hospitalized veterans under authority of a statute enacted by Congress, a law that has not been repealed. To do so would suggest the government abetted misconduct.

Congress's action to prohibit service connection for smoking-related illnesses was inequitable and inconsistent with the government's position on who is responsible for the adverse health effects of smoking. During decades of litigation, the cigarette manufacturers paid not even a single dollar in damages for the injurious effects of smoking. They successfully invoked the defense that smokers were personally responsible for the consequences of smoking because they "assumed the risk" by knowingly using a potentially harmful product. Those suing the tobacco companies persisted, nonetheless, and that defense is no longer recognized as viable because it has come to light that the tobacco companies concealed from consumers much about the injurious and addictive effects of tobacco use.

It was on the premise that cigarette manufacturers, and not smokers, are responsible for the effects of smoking that state governments and the federal government recouped from the tobacco industry billions of dollars for costs of tobacco-related health care provided to government beneficiaries. Yet, the Clinton administration disingenuously invoked the very defense the government rejected as an excuse for depriving veterans of compensation. Congress, seeing that this was the way to fund its own pork-barrel spending, seized upon the president's proposal.

While the government's position in the litigation against tobacco companies rested on the premise that these consumers could not themselves be held responsible for their own tobacco use inasmuch as they were not undertaking a potentially harmful activity with full knowledge of its risks and probable consequences, the president's proposal to prohibit compensation for veterans rested on a contrary premise. The contrary premise was that veterans were somehow in a position of knowledge and

understanding superior to that of all other consumers and thereby voluntarily exposed themselves to a known danger of which they appreciated the nature and extent and thus must be held personally responsible and not entitled to compensation.

There was no proposal to prohibit other government benefits on this basis. For example, disability and health-care benefits continue under other federal programs even though smoking may have played a role in causing the illness and disability.

Accordingly, considering that smoking was encouraged by the armed forces with the result of a higher incidence of smoking among veterans, considering that veterans were no more aware of the inherent risks of smoking than the general public, and considering that no other federal programs prohibit disability or medical benefits for conditions related to smoking, no rational basis exists for holding veterans to a different standard and singling them out for disparate and punitive treatment.

In its quest to use veterans' benefits to fund increased spending on transportation, Congress paid little attention to the merits of a prohibition against service connection. The manner in which the provision was enacted demonstrates that it was the money and not the merits that provided the momentum behind this legislation.

Certainly it is arguable that anyone entering military service today should be deemed to have full knowledge of the risks of smoking. We would not oppose a prohibition of service connection for disabilities shown by clear and convincing evidence to have been caused by smoking alone if the law applied to persons who enter military service on or after the date of enactment of the law. The current prohibition should be repealed, however.

Recommendation:

Congress should repeal its prohibition on service connection for smoking-related disabilities.



Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

The Department of Veterans Affairs (VA) disability rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable evaluation for hearing loss at certain levels severe enough to require hearing aids. The minimum rating for any hearing loss warranting use of hearing aids should be 10 percent, however.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial restoration of hearing, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of disability compensation that ratings are not offset by the function artificially

restored by prosthesis. For example, a veteran receives full compensation for amputation of a lower extremity though he or she may ambulate with a prosthetic limb. Providing a compensable rating would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication.

Recommendation:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability evaluation for any hearing loss for which a hearing aid is medically indicated.

Temporary Total Compensation Awards:*Temporary awards of total disability compensation should be exempted from delayed payment dates.*

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence.

Hospitalization in excess of 21 days for a service-connected disability entitles the veteran to a temporary total disability rating. This rating is effective the first day of hospitalization and continues to the last day of the month of hospital discharge. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary total rating is awarded effective the date of hospital admission or outpatient visit.

While the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, under 38 U.S.C. § 5111 the effective date for payment purposes is delayed until the first day of the month following the effective date of the increased rating.

This provision deprives veterans of any increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprivation and consequent delay in the payment of increased compensation often jeopardizes disabled veterans' financial security and unfairly causes them hardships.

Therefore, *The Independent Budget* veterans service organizations urge Congress to enact legislation exempting these temporary total ratings, under 38 C.E.R. §§ 4.29, 4.30, from the provisions of 38 U.S.C. § 5111.

Recommendation:

Congress should amend the law to authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

**Dependency and Indemnity Compensation****Repeal of Offset Against Survivor Benefit Plan:***The current requirement that the amount of an annuity under the Survivor Benefit Plan be reduced on account of, and by an amount equal to, dependency and indemnity compensation (DIC) is inequitable.*

A veteran disabled in service in our armed forces is compensated for the effects of the service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors receive DIC from the Department of Veterans Affairs. This benefit indemnifies survivors for the losses associated with the veteran's death from service-connected causes or after a period of time when the

veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the Survivor Benefit Plan (SBP), deductions are made from the member's retired pay to purchase a survivors' annuity.

This is not a gratuitous benefit. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes, or was not totally disabled by service-connected causes for the required time preceding his or her death, beneficiaries receive full SBP payments. However, if the veteran's death was due to service-connected causes or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. Where the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

This offset is inequitable because no duplication of benefits is involved. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

Recommendation:

Congress should repeal the offset between dependency and indemnity compensation and the Survivor Benefit Plan.



READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

Service members who in every respect are at least equally entitled to participate in the Montgomery GI Bill as service members who first entered military service after June 30, 1985, are ineligible if they entered or had military service before that date.

Under current law, an active duty service member must have first become a member of the armed forces after June 30, 1985, to be eligible to participate in the Montgomery GI Bill. An active duty service member who entered the armed forces before that date and continues to serve cannot participate—unless he or she was enrolled in the prior educational assistance program and elected to convert to the Montgomery GI Bill. In this situation, service members who have served longer and are arguably more deserving of educational benefits are treated less favorably than members who have served in the armed forces for shorter periods.

Any person who was serving in the armed forces on June 30, 1985, or any person who reentered service in the armed forces on or after that date, if otherwise eligible, should be allowed to participate in the Montgomery GI Bill under the same conditions as members who first entered military service after that date.

Recommendation:

Congress should amend the law to remove the restriction on eligibility to the Montgomery GI Bill to those who first entered military service after June 30, 1985.



Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

The government should refund the contributions of individuals who become ineligible for the Montgomery GI Bill because of general discharges or discharges under honorable conditions.

The Montgomery GI Bill-Active Duty program provides educational assistance to veterans who first entered active duty (including full-time National Guard duty) after June 30, 1985. To be eligible, service members must have elected to participate in the program and made monthly contributions from their military pay. These contributions are not refundable.

Eligibility is also subject to an honorable discharge. Discharges characterized as “under honorable conditions” or “general” do not qualify. *The Independent Budget* veterans service organizations believe that in

the case of a discharge that involves a minor infraction or deficiency in the performance of duty the individual should at least be entitled to a refund of his or her contributions to the program.

Recommendation:

Congress should change the law to permit refund of an individual’s Montgomery GI Bill contributions when his or her discharge was characterized as “general” or “under honorable conditions” because of minor infractions or inefficiency.

**Housing Grants****Increase in Amount of Grants and Automatic Annual Adjustments for Inflation:**

Housing grants and home adaptation grants for seriously disabled veterans need to be adjusted automatically each year to keep pace with the rise in the cost of living.

The Department of Veterans Affairs provides specially adapted housing grants of up to \$50,000 to veterans with service-connected disabilities consisting of certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries. Veterans with service-connected blindness alone or with loss or loss of use of both upper extremities may receive a home adaptation grant of up to \$10,000.

Increases in housing and home adaptation grants have been infrequent, although real estate and construction costs rise continually. Unless the amounts of the grants

are periodically adjusted, inflation erodes the value and effectiveness of these benefits, which are payable to a select few but who include the most seriously disabled service-connected veterans. Congress should increase the grants this year and amend the law to provide for automatic adjustment annually.

Recommendation:

Congress should increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost-of-living.



Grant for Adaptation of Second Home:

Grants should be available for special adaptations to homes that veterans purchase or build to replace initial specially adapted homes.

Like those of other families today, veterans' housing needs tend to change with time and new circumstances. An initial home may become too small when the family grows or become too large when children leave home. Changes in the nature of a veteran's disability may necessitate a home configured differently and/or changes in the special adaptations. These

things merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

Congress should establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

**Automobile Grants and Adaptive Equipment**

**Increase in Amount of Grant and
Automatic Annual Adjustments for Increased Costs:**

The automobile and adaptive equipment grants need to be increased and automatically adjusted annually to cover increases in costs.

VA provides certain severely disabled veterans and service members grants for the purchase of automobiles or other conveyances. This grant also provides for adaptive equipment necessary for safe operation of these vehicles. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. This program also authorizes replacement or repair of adaptive equipment.

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. With subsequent cost-of-living increases in the grant, Congress sought to provide 85 percent of the average cost of a new automobile, and later 80 percent. Until the 2001 increase to \$9,000, the amount of the grant had not been adjusted since 1988, when it was set at \$5,500.

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the \$1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in

1997 the allowance was \$5,500, and the average retail cost of new automobiles was \$21,750, according to the National Automobile Dealers Association. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of \$5,500 was only 343 percent of the 1946 award. Currently, the \$11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile, which is \$27,782. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be \$22,226.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current \$11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80 percent of the average cost of a new automobile in 2004. And to avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

Recommendation:

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile and provide for automatic annual adjustments in the future.



Home Loans

No Increase in, and Eventual Repeal of, Funding Fees:

Funding fees are contrary to the principles underlying our benefit programs for veterans, and increased funding fees are negating the benefits and advantages of Department of Veterans Affairs (VA) home loans.

Congress initially imposed funding fees upon VA guaranteed home loans under budget reconciliation provisions as a temporary deficit reduction measure. Now, loan fees are a regular feature of all VA home loans except those exempted. During its first session, the 108th Congress increased these loan fees. The purpose of the increases was to generate additional revenues to cover the costs of improvements and cost-of-living adjustments in other veterans programs. In effect, this legislation requires one group of veterans (and especially our young active duty military), those subject to loan fees, to pay for the benefits of another group of veterans, those benefiting from the programs improved or adjusted for increases in the cost of living.

tions and sacrifices through service in the armed forces, should be entirely free. In addition, the *IB* finds it entirely indefensible that Congress can only make improvements or adjustments in veterans' programs for inflation by shifting the costs onto the backs of other veterans. The government, not veterans, should bear the costs of veterans' benefits. With these increased funding fees, the advantages of VA home loans for veterans are being negated. These fees are increasing the burdens upon veterans purchasing homes while the intent of VA's home loan program is to lessen the burdens.

Recommendation:

First and foremost, it is the position of *The Independent Budget (IB)* that veterans' benefits, provided to veterans by a grateful nation in return for their contribu-

Congress should refrain from further increasing home loan funding fees and should, as soon as feasible, repeal these fees entirely.



INSURANCE

Government Life Insurance

Value of policies excluded from consideration as income or assets.

For purposes of other government programs, the cash value of veterans' life insurance policies should not be considered assets, and dividends and proceeds should not be considered income.

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance policies and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to

receive nursing home care. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other government programs.

Recommendation:

Congress should enact legislation to exempt the cash value of, and dividends and proceeds from, VA life insurance policies from consideration in determining entitlement under other federal programs.



Service-Disabled Veterans' Insurance

Lower Premium Schedule to Reflect Improved Life Expectancy:

The Department of Veterans Affairs (VA) should be authorized to charge lower premiums for Service-Disabled Veterans' Insurance (SDVI) policies based on improved life expectancy under current mortality tables.

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. VA therefore offers disabled veterans life insurance at standard rates under the SDVI program. When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. VA continues to base its rates on

mortality tables from 1941 however. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

Recommendation:

Congress should enact legislation to authorize VA to revise its premium schedule for SDVI to reflect current mortality tables.



Increase in Maximum SDVI Coverage:

The current \$10,000 maximum for life insurance under Service-Disabled Veterans' Insurance (SDVI) does not provide adequately for the needs of survivors.

When life insurance for veterans had its beginnings in the War Risk Insurance program, first made available to members of the armed forces in October 1917, coverage was limited to \$10,000. At that time, the law authorized an annual salary of \$5,000 for the director of the Bureau of War Risk Insurance. Obviously, the average annual wages of service members in 1917 was considerably less than \$5,000. A \$10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured service member in 1917.

Today, more than 87 years later, maximum coverage under the base SDVI policy is still \$10,000. Given that the annual cost of living is 1,375 percent higher than what it was in 1917, the same maximum coverage well over three quarters of a century later clearly does not

provide meaningful income replacement for the survivors of service-disabled veterans.

In the May 2001 report from an SDVI program evaluation conducted for the Department of Veterans Affairs, it was recommended that basic SDVI coverage be increased to \$50,000 maximum. *The Independent Budget* veterans service organizations therefore recommend that the maximum protection available under SDVI be increased to at least \$50,000.

Recommendation:

Congress should enact legislation to increase the maximum protection under base SDVI policies to at least \$50,000.

**Veterans' Mortgage Life Insurance****Increase in VMLI Maximum Coverage:**

The maximum amount of mortgage protection under Veterans' Mortgage Life Insurance (VMLI) needs to be increased.

The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover,

severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

Recommendation:

Congress should increase the maximum coverage under VMLI from \$90,000 to \$150,000.



OTHER SUGGESTED BENEFIT IMPROVEMENTS

Protection of Veterans' Benefits Against Claims of Third Parties

Restoration of Exemption from Court-Ordered Awards to Former Spouses:

Through interpretation of the law to suit their own ends, the courts have nullified plain statutory provisions protecting veterans' benefits against claims of former spouses in divorce actions.

Congress has enacted laws to ensure veterans' benefits serve their intended purposes by prohibiting their diversion to third parties. To shield these benefits from the clutch of others who might try to obtain them by a wide variety of devices or legal processes, Congress fashioned broad and sweeping statutory language. Pursuant to 38 U.S.C. § 5301(a), "[p]ayments of benefits due or to become due under any law administered by the Secretary shall not be assignable except to the extent specifically authorized by law, and such payments made to, or on account of, a beneficiary shall be exempt from taxation, shall be exempt from the claim of creditors, and shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever, either before or after receipt by the beneficiary."

Thus while as a general rule an individual's income and assets should rightfully be subject to legal claims of others, the special purposes and special status of veterans' benefits trump the rights of all others except liabilities to the U.S. Government. Veterans cannot voluntarily or involuntarily alienate their rights to veterans' benefits. The justification for this principle in public policy is one that can never obsolesce with the passage of time or changes in societal circumstances.

However, unappreciative of the special character and superior status of veterans' rights and benefits, the courts have supplanted the will and plain language of Congress with their own expedient views of what the public policy should be and their own convenient interpretations of the law. The courts have chiseled away at the protections in § 5301 until this plain and forceful language has, in essence, become meaningless. Various courts have shown no hesitation to force

disabled veterans to surrender their disability compensation and sole source of sustenance to able-bodied former spouses as alimony awards, although divorced spouses are entitled to no veterans' benefits under veterans' laws. The welfare of ex-spouses has never been a purpose for dispensing veterans' benefits.

We should never lose sight of the fact that it is the veteran who, in addition to a loss in earning power, suffers the pain, limitations in the routine activities of daily life, and the other social and lifestyle constraints that result from disability. The needs and well-being of the veteran should always be the primary, foremost, and overriding concern when considering claims against a veteran's disability compensation. Disability compensation is a personal entitlement of the veteran, without whom there could never be any secondary entitlement to compensation by dependent family members. Therefore federal law should place strict limits on access to veterans' benefits by third parties to ensure compensation goes mainly to support veterans disabled in the service of their country. Congress should enact legislation to override judicial interpretation and leave no doubt about the exempt status of veterans' benefits.

Recommendation:

Congress should amend 38 U.S.C. § 5301(a) to make its exemption of veterans' benefits from the claims of others applicable "notwithstanding any other provision of law" and to clarify that veterans' benefits shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever "for any purpose."



General Operating Expenses

The Department of Veterans Affairs (VA) administers veterans' benefits programs through its central office in Washington, DC, and a nationwide system of regional and benefit offices. Responsibility for the various benefit programs is divided among five different services within the Veterans Benefits Administration (VBA): Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Loan Guaranty, and Insurance. Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from VA's Central Office. The field offices receive benefit applications, determine entitlement, and authorize benefit payments and awards.

The Office of the Secretary of Veterans Affairs and the assistant Secretaries provide departmental management and administrative support. These offices along with the Office of General Counsel and the Board of Veterans' Appeals are the major activities under the general administration portion of the general operating expenses (GOE) appropriation. The GOE appropriation funds the benefits delivery system—VBA and its constituent line, staff, and support functions—and the functions under general administration.

The Independent Budget veterans service organizations make the following recommendations for improving VA performance and service to veterans.

General Operating Expenses (GOE) (in thousands)

FY 2005	\$1,324,753
FY 2006 Administration Request	1,407,865
FY 2006 <i>Independent Budget</i> Recommendation	1,550,535

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

Veterans Benefits Administration Management

Line Authority Over Field Offices:

*Department of Veterans Affairs (VA) program directors
should have line authority over benefits administration in the field offices.*

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions.

VBA's current management structure presents a serious obstacle to enforcement of accountability, however, because program directors lack line authority over those who make claims decisions. Of VBA management, program directors have the most hands-on experience with and intimate knowledge of their benefit lines and have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to enforce quality standards and program policies within their respective benefit programs. While higher level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have authority over the decision-making process and should be able to order remedial measures when variances are identified.

In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed much of VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action permeates the VBA. In turn, field personnel perceived VBA's Central Office staff as incapable of

taking firm action. NAPA said that a number of executives interviewed by its study team indicated VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that until the VBA is willing to deal with this conflict and modify its decentralized management style it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding the Compensation and Pension Service (C&P) especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability. NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability.

In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment Task Force recommended that the director of Vocational Rehabilitation and Employment Service be given "some line-of-sight authority for the field administration of the program."

Recommendation:

To make the management structure in the VBA more effective for purposes of enforcing program standards and accountability for quality, VA's Under Secretary for Benefits should give VBA's program directors line authority over VA field office directors.



Departmental Policy for Veterans Programs

Improvements in Rulemaking:

Today's Department of Veterans Affairs (VA) is misusing its rulemaking authority for self-serving purposes and to orchestrate an insidious erosion of veterans' rights.

From America's beginnings, our citizens recognized that our nation's very existence and future depended on a strong army and navy. They appreciated the fundamental necessity and exceptional value of military service. On the principle that those who devote part of their youth and risk their lives and health to defend their country deserve special treatment and advantages over those who do not, our people have, through Congress, accorded veterans special honors and provided for generous benefits. Consistent with our indebtedness to veterans and our deep appreciation for their contributions and sacrifices, our citizens have charged VA with providing veterans seeking benefits with the highest level of personal service and assistance in obtaining those benefits. Every effort is to be made to help veterans apply for, and establish entitlement to, the benefits they claim; within the law, VA must endeavor to grant them the benefits they seek. For VA to create procedural impediments or substantive rules to limit veterans' rights offends the very essence and spirit of benefits for veterans and is antithetical to the intent of our grateful nation as expressed in the laws of Congress.

Congress has repeatedly stated its intent that the ultimate goal of VA's unique process is to ensure veterans receive every benefit to which they are entitled. That goal overrides agency convenience and expedience, and toward that end, the VA system must afford veterans advantages not afforded to claimants in other agencies. When enacting legislation to improve the process, Congress has frequently sought to preempt any misinterpretation of its intent that would formalize or make VA claims procedures burdensome for veterans. On these occasions, Congress has gone to great lengths to emphasize and reaffirm its intent to preserve the "pro-claimant bias," informality, and helpful nature of the process. Congress expressly stated it intends that no changes be made to the existing system except to further the goals, informality, accuracy, and fairness.

The federal courts have reaffirmed on many occasions the principle that laws governing veterans' benefits are to be liberally construed in favor of veterans. It is a well-settled rule of statutory construction that ambiguities in such statutes are to be resolved in favor of veterans.

Historically, VA's regulations were drafted to reflect these benevolent goals and the special treatment and considerations to be accorded veterans seeking benefits. For example, a longstanding VA regulation begins with this declaration: "It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation." 38 C.F.R. § 3.102. In another regulation, the essence of VA policy is articulated with this statement: "Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government." 38 C.F.R. § 3.103.

Regrettably, with its decisions immune to judicial review and VA operating in what has been described as a state of "splendid isolation" for most of the 20th century, VA adjudicators often ignored the liberal provisions of VA regulations. With the advent of judicial review, the courts began enforcing the letter and spirit of the law and these regulations. In reaction, VA began to construe the statutes as narrowly as possible to limit veterans' entitlements, and it began to rewrite its rules in ways designed to diminish veterans' rights, to make the process more burdensome and formal, and to serve for VA's own advantage, convenience, and purposes rather than to serve the interests of veterans.

Generally, when VA writes new regulations, they no longer have the traditional pro-veteran tone. They often have a negative, restrictive focus. They appear calculated to give VA the upper hand against claimants and to impair veterans' due process rights or access to an open claims process and benefits. Today's VA regu-

lations are too often self-serving: They are designed for VA expedience and to incorporate VA's resistance to liberalizing legislation. Sometimes, their apparent aim is to inhibit what VA cannot prohibit. VA exploits opportunities to reinterpret statutory provisions to remove from its longstanding regulations provisions that are favorable to veterans. With aloofness, VA pays little real attention to public comments and offers flimsy rationales for brushing them aside. VA's justifications in response to public comments sometimes suggest pretext and are tenuous, specious, shallow, or as arbitrary as the text of the rules themselves. VA vigorously defends narrow or restrictive judicial interpretations of its regulations that are adverse to veterans but actively seeks to overturn judicial constructions that are more favorable to veterans than VA desires.

Outraged veterans organizations have begun to challenge VA's regulations more frequently, but, consistent with courts' tendency to indulge federal agencies, the results have been mixed, despite special canons of statutory construction intended to favor veterans. While veterans organizations have had some successes in getting the most objectionable regulations invalidated, the courts have sometimes strained to defer to VA rules, and veterans organizations have sometimes not prevailed even in exceptionally meritorious challenges. As one court noted, this practice of judicial deference "all too often is taken to mean simply that administrative agencies win any dispute involving statutory construction." *Mid-America Care Foundation v. National Labor Relations Board*, 148 F.3d 638, 642 (6th Cir. 1998). VA's awareness of these circumstances appears to embolden it in its arbitrary rulemaking.

In matters of veterans' rights, this type of agency behavior must not be tolerated. If the Secretary of Veterans Affairs is unwilling to rein in those who write his regulations and if the courts continue to permit

such behavior, Congress should act to impose special constraints and requirements upon VA's rulemaking to ensure VA carries out the will of the people to treat veterans as a special class; to ensure that VA does not deal with veterans grudgingly, indifferently, or at arm's length as if they were ordinary litigants or claimants for federal benefits; and certainly to ensure that VA does not treat veterans like adversaries.

As has often been observed, veterans have unique needs; the nation has an extraordinary obligation to meet those needs; and the VA system is therefore a unique system with an extraordinary mission. The procedures, rules, and remedies of other forums or agencies are frequently improperly suited or inadequate for the administration of veterans' programs. In view of the hardening of VA's regulations and its departure from the benevolent role assigned to it by Congress, specially tailored laws may become necessary to bring VA's rulemaking back in line with its unique mission as the nation's patron and benefactor for veterans.

Recommendations:

The Secretary of Veterans Affairs should act decisively to put an end to VA's self-serving rulemaking; if he does not, Congress should

- (1) scrutinize VA's rulemaking more closely as part of its oversight role;
- (2) intervene to override VA rules that run counter to congressional intent; and
- (3) enact special provisions to control VA rulemaking if the Secretary of Veterans Affairs fails to bring VA's rulemaking back in line with congressional intent and VA's benevolent mission.



*Information Technology Test Center***Funding to Support Continued Predeployment
of Information Technology (IT) Upgrades**

To ensure new information technology applications are tested for performance before they are put into service in field offices, the Department of Veterans Affairs (VA) must maintain testing capacity at its Hines Information Technology Center.

By automated testing of new information technology at the Hines test center, field office staff are not diverted from their regular duties to test new applications. Adequate funding must be provided to avoid reductions in system upgrades or deployment of untested software to VA field offices. Based on experience, it is estimated that \$4 million will be needed to fund this activity in FY 2006.

Recommendation:

Congress should provide \$4 million in FY 2006 for testing of information technology at VA's Hines Information Technology Center.

**Training for Information Technology Personnel**

The Department of Veterans Affairs (VA) information technology staff needs regular training to stay abreast of continual changes in information technology (IT) systems.

Information systems are undergoing constant and rapid changes. Both Veterans Benefits Administration's (VBA) current and new IT staff of more than 300 stationed at the VA Central Office; the Hines, Illinois, and Philadelphia, Pennsylvania, Information Technology Centers; and the Austin, Texas, and St. Petersburg, Florida, System Development Centers must be trained in such areas as equipment upgrades, new programming, and

database development. Based on experience, it is estimated that the VBA will need \$1 million to cover the costs of IT training in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide \$1 million to fund training of VBA's information technology staff in FY 2006.



Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To overcome the persistent and longstanding problem of large claims backlogs and consequent protracted delays in the delivery of crucial disability benefits to veterans and their families, the Administration must invest adequate resources in a long-term strategy to improve quality, proficiency, and efficiency within the Veterans Benefits Administration (VBA).

A core mission of the Department of Veterans Affairs (VA) is the provision of benefits to relieve the economic effects of disability upon veterans and their families. For those benefits to effectively fulfill their intended purpose, VA must promptly deliver them to veterans. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on these benefits. The need for benefits among disabled veterans is generally urgent. While awaiting action by VA, they and their families suffer hardships; protracted delays can lead to deprivation and bankruptcies. Disability benefits are critical, and providing for disabled veterans should always be a top priority of the government.

VA can promptly deliver benefits to entitled veterans only if it can process and adjudicate claims in a timely and accurate fashion. Given the critical importance of disability benefits, VA has a paramount responsibility to maintain an effective delivery system, taking decisive and appropriate action to correct any deficiencies as soon as they become evident. However, VA has neither maintained the necessary capacity to match and meet its claims workload nor corrected systemic deficiencies that compound the problem of inadequate capacity.

Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in claims disposition, VA has lost ground to the problem, with the backlog of pending claims growing substantially larger. In *The Independent Budget for Fiscal Year 2005*, we observed that VA had increased its monthly claims decisions by more than 70 percent despite a workforce with many inexperienced adjudicators and other factors that would be expected to slow production. With the emphasis on production targets and a corresponding compromise in quality, we warned that the reduction in pending caseload would likely be temporary:

With [VA's] continued net decline in accuracy over the past 3 years, the number of claims needing additional work to correct errors is likely to rise. Accordingly, while the unmanageable claims backlog would appear on the surface to have been largely overcome for the present, the true amount of claims work awaiting VA may be greater than indicated by the inventory of currently pending claims. The backlog of pending claims may very well again begin to quickly grow, repeating the familiar vicious cycle in which poor quality necessitates rework and results in increased workloads, increased backlogs, decline in timeliness, and greater pressure to increase production at the expense of quality. Gains on the claims backlog through increased production at the expense of quality are merely cosmetic and temporary.

Regrettably, that scenario has materialized. The claims backlog has swollen, and the appellate workload is growing at an alarming rate, suggesting further degradation of quality or at least continuation of quality problems.

Historically, many underlying causes acted in concert to bring on this now intractable problem. These include mismanagement, misdirected goals, the wrong focus on mere cosmetic fixes, poor planning and execution, and denial and excuses rather than real strategic remedial measures. These dynamics, acting in concert, have been thoroughly detailed in several studies into the problem. While the problem has been exacerbated by lack of appropriate and decisive action, most of the causes can be directly or indirectly associated with inadequate resources. The problem was primarily triggered and is now perpetuated by insufficient resources.

Insufficient resources are the result of misplaced priorities, in which the agenda is to reduce spending on veterans' programs despite a need for greater resources

to meet a growing workload in a time of war and a need for added resources to overcome the deficiencies and failures of the past. Instead of requesting the additional resources needed, the President has sought and Congress has provided fewer resources. Recent budgets have sought reductions in full-time employees for the VBA in fiscal years 2003, 2004, and 2005. Such reductions in staffing are clearly at odds with the realities of VA's workload and its failure to improve quality and make gains against the claims backlog. During congressional hearings, *VA is forced to defend a budget that it knows is inadequate.*

The priorities and goals of the immediate political strategy are at odds with the need for a long-term strategy by VA to fulfill its mission and the nation's moral obligation to disabled veterans in an effective manner. VA must have a long-term strategy focused principally on attaining quality and not merely achieving production numbers. It must have adequate resources, and it must invest them in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can the claims backlog really be overcome. Only then will the system serve disabled veterans in a satisfactory

fashion, in which their needs are addressed timely with the effects of disability alleviated by prompt delivery of benefits. Veterans who suffer disability from military service should not also have to needlessly suffer economic deprivation because of the inefficiency and indifference of their government.

To end this long series of repeated failures from inadequate resources and misplaced priorities, *The Independent Budget* will recommend funding levels for fiscal year 2006 adequate to meet the real staffing (see "Sufficient Staffing Levels" discussion) and other needs of the VBA.

Recommendations:

Congress and the administration must provide adequate funding to ensure that the Veterans Benefits Administration can process quality claims in a timely manner.

VA must develop a long-term strategy focused on improving quality, proficiency, and efficiency and not merely on achieving production numbers.



Sufficient Staffing Levels:

With a probable increase in compensation claims, the Department of Veterans Affairs (VA) must maintain staffing at least at its fiscal year 2004 (FY 2004) level for the Compensation and Pension (C&P) Service.

Within VA, the pressing imperative to overcome persisting large claims backlogs and consequent delays for veterans in need of disability benefits means that the C&P Service must have adequate personnel. At the same time, external factors are increasing the workload on this service. With the casualties of the war in Iraq and the ongoing combat operations in Afghanistan, VA is receiving additional new claims. New legislation authorizing concurrent receipt of disability compensation and pay based on military retirement has also added to the workload. It is estimated that disability claims will increase by approximately 8 percent in 2005 and, along with the carryover into FY 2006, continue at higher levels indefinitely into the future.

During FY 2004, VA's actual staffing level in the C&P Service was 8,929 full-time employee equivalents (FTEEs). Authority for fewer FTEEs in the FY 2006 budget will add to the existing severe strains and

inability to overcome the longstanding quality and timeliness problems that have plagued that business line. Unavoidably, the pending caseload will grow to even more unacceptable levels, as will processing times and waiting times for disabled veterans. Other services provided by C&P will also likely deteriorate, such as phone service and Benefits Delivery at Discharge, an activity proven to save resources and more promptly deliver benefits to disabled veterans.

These realities cannot fairly or wisely be ignored. They require that VA maintain its staffing levels of 8,929 FTEEs for the C&P Service in FY 2006.

Recommendation:

Congress should authorize 8,929 total FTEEs for the C&P Service in FY 2006.

**Improved Claims Processing with Information Technology:**

To meet its workload demands and fulfill its mission of delivering benefits and services to veterans, the Department of Veterans Affairs (VA) must develop and install modern information technology.

For a claims processing and awards program as massive as VA's, modern data systems are indispensable. VA is in the midst of developing and deploying applications, or subsystems, for compensation and pension to be incorporated in a new integrated system (VETSNET), a replacement for its antiquated and inadequate Benefits Delivery Network (BDN) system. This involves design, development, and converting or migrating data from the old legacy database manage-

ment system to a modern enterprisewide system. For a new hardware platform and conversion of data from legacy to the new system, VA will need \$12 million in fiscal year 2006.

Recommendation:

Congress should provide \$12 million to continue development of VETSNET in FY 2006.



Improved Claims Processing with Electronic Files:

To improve its business processes through reliance on more efficient modern information technology, the Department of Veterans Affairs (VA) needs to acquire, store, and process claims data in electronic files.

VA is moving toward more modern and efficient methods of compensation and pension claims processing by replacing its paper-based claims system with electronic imaging. VA's project, known as "Virtual VA," has been deployed at VA's pension maintenance centers and is undergoing evaluation and assessment based on experience at these three sites. With eventual full implementation, all Veterans Benefits Administration (VBA) regional offices will have document-imaging capabilities, and VA medical centers will have electronic access to veterans' claims folders for review in connection with disability examinations. VA expects better timeliness and accuracy in claims decisions when the system is fully deployed.

To continue document preparation and scanning at the pension maintenance centers and evaluation of the system for use nationwide, VA needs \$2 million in fiscal year 2006.

Recommendation:

Congress should provide \$2 million to support continuing use of VA's Virtual VA electronic file system at its pension maintenance centers and to continue evaluation of the system for eventual installation in all VBA regional offices.

**Vocational Rehabilitation and Employment****Adequate Staffing Levels:**

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's Vocational Rehabilitation and Employment (VR&E) Task Force, VR&E needs to increase its staffing.

During fiscal year 2005 (FY 2005) and continuing into FY 2006, VR&E's workload is expected to increase between 10 percent and 13 percent primarily as a consequence of the war in Iraq and ongoing military operations in Afghanistan. Also, given its increased reliance on contract services, VR&E needs approximately 60 additional full-time employee equivalents (FTEs) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended in its March 2004 report the creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To meet its increasing workload and implement reforms to improve the effectiveness and efficiency of its programs, it is projected that VR&E will need a minimum of 1,017 direct program FTEs in FY 2006, approximately 94 more than current staffing in that program.

Recommendation:

Congress should authorize 1,017 direct program FTEs for the Vocational Rehabilitation and Employment Service for FY 2006.

Expansion of Case Management and Information System:

Vocational Rehabilitation and Employment (VR&E) can attain additional processing efficiencies by proceeding with its linkage of its Corporate WINRS case and information management system to the Internet.

VR&E's case management and information system is WINRS, also called Corporate WINRS. Since its introduction of WINRS in 1997, the Department of Veterans Affairs (VA) has refined and expanded the functions of the system to allow management and sharing claims information by VA offices nationwide. To allow for more efficient award processing and sharing of information with contractors, employment services, and outside partnership entities, VA needs to Web-enable the system in fiscal year 2006 (FY 2006).

For this phase of the system's development, it is estimated VA will need \$3 million.

Recommendation:

Congress should provide \$3 million in FY 2006 to enable VR&E to expand its automated case management and information system, WINRS, to include a Web-based version.

**Internet Application:**

For efficiency, Vocational Rehabilitation and Employment (VR&E) needs the capacity for electronic data exchange with education and training institutions and to allow veterans to confirm enrollment and other pertinent information via the Internet.

With the capacity to interact electronically with claimants and schools over the Internet, VR&E can significantly reduce cumbersome and inefficient manual processes by electronically receiving enrollment information from schools and having online contact between veterans and case managers. In addition, VR&E can enhance its automation of award process-

ing. For this initiative, it is estimated that VA will need \$2 million in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide \$2 million in FY 2006 to fund VR&E's Internet Application Initiative.



Education Service**Adequate Staffing:**

To sustain services at current levels and meet added workload demands consequent to liberalizations in education programs, the Department of Veterans Affairs (VA) Education Service needs to retain its fiscal year 2003 (FY 2003) staffing level.

As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. However, with the inability to hire new employees during FY 2004, Education Service timeliness in processing original and supplemental education claims declined during FY 2004. In addition, legislation authorizing a new education benefit for members of the National Guard and Reserves pressed into active service for 90 or more days will add to the existing workload during FY 2005 and future years, making it even more difficult to address the education caseload in a timely manner. Without an increase in staffing adequate to meet the existing and added workload, service to veterans seek-

ing educational benefits will continue to decline. Based on experience with the average number of claims decisions a claims examiner can process and the average number of telephone and Internet contacts an employee can handle, to meet its workload demands in a satisfactory fashion, VBA must increase direct program staffing in its Education Service in FY 2006 to 770 full-time employee equivalents (FTEs), 33 FTEs more than requested for FY 2005.

Recommendation:

Congress should authorize 770 direct program FTEs for VA's Education Service.

**Further Enhancement of Imaging Technology Needed:**

To improve and maintain its capacity for electronic processing, management, and storage of education claims, Department of Veterans Affairs (VA) Education Service must continue enhancing TIMS (The Imaging Management System).

TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. VA needs to consolidate four separate TIMS databases into one database accessible by the Internet and add capacity to meet increased workload demands. This will make the system fully interactive nationwide and will include the critical additional capacity necessary for continued viability of the system. It is estimated that this initia-

tive will require \$2 million in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide \$2 million for necessary enhancements of the Education Service's Imaging Management System in FY 2006.



Loan Guaranty Service**Increased Efficiency with Enhancement of Information Technology:**

To continue to achieve greater effectiveness and efficiency of its data systems, the Loan Guaranty Service needs to upgrade and expand online access to its data systems.

Through its Loan Servicing System, which includes online interface with lenders, the Department of Veterans Affairs (VA) operates an automated system to service loans and increasingly is allowing Web-based access by claimants. The long-term information technology (IT) enterprise architecture plan and business process strategy necessarily include ongoing upgrading and expansion of these systems to better meet the needs of data systems in today's environment. To upgrade its Loan Servicing System and to allow

claimants direct access to its Automated Certificate of Eligibility application, Loan Guaranty will need an estimated \$3 million in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide \$3 million in FY 2006 for upgrading and expansion of the Loan Guaranty Service's IT systems.



Judicial Review in Veterans' Benefits

Although the Department of Veterans Affairs (VA) has the sole authority to adjudicate claims for veterans' benefits, VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established what is now the United States Court of Appeals for Veterans Claims (CAVC) to review appeals from VA's Board of Veterans' Appeals (BVA), it added another beneficial element to appellate review. It created oversight of VA decision making by an independent, impartial tribunal from a separate branch of government.

For the most part, judicial review of the claims decisions of VA has lived up to the positive expectations of its proponents. To some extent it has also brought about some of the adverse consequences foreseen by its opponents. Based on past recommendations in *The Independent Budget*, Congress made some important adjustments to correct some of the unintended effects of the judicial review process. In its initial decisions construing these changes, the CAVC has not given them the effect intended by Congress to ensure that veterans have meaningful judicial review in all aspects of their appeals. More precise adjustments are still needed to conform CAVC review to congressional intent.

In addition, most of VA's rulemaking is subject to judicial review. Here again, changes are needed to bring the positive effects of judicial review to all of VA's rulemaking.

Accordingly, *The Independent Budget* veterans service organizations make the following recommendations to improve the process of judicial review in veterans' benefits matters.

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

To achieve its intent that the court enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the Court of Appeals for Veterans Claims (CAVC) scope of review.

The CAVC upholds VA's factual findings unless they are clearly erroneous. Clearly erroneous is the standard for appellate court reversal of a district court's findings. When there is a "plausible basis" for a factual finding, it is not clearly erroneous under the case law from other courts, which the CAVC has applied to the Board of Veterans' Appeals (BVA) findings.

Under the statutory "benefit-of-the-doubt" standard, the BVA is required to find in the veteran's favor when the veteran's evidence is at least of equal weight as that against him or her, or stated differently, when there is not a preponderance of the evidence against the veteran. Yet, the court has been affirming any BVA finding of fact when the record contains the minimal evidence necessary to show a plausible basis for such finding. This renders the statutory benefit-of-the-doubt rule meaningless because veterans' claims can be denied and the denial upheld when supported by far less than a preponderance of evidence against the veteran.

To correct this situation, Congress amended the law to expressly require the CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. With this statutory requirement, the CAVC can no longer properly uphold a BVA finding of fact solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the CAVC's decision must take into account whether the factual finding adheres to the benefit-of-the-doubt rule. The court can no longer end its inquiry after merely searching for and finding a plausible basis for a factual determination. Congress intended for the CAVC to afford a meaningful review of both factual and legal determinations presented in an appeal before the court. Congress also

amended the law to specify that the CAVC should, as a general rule, reverse erroneous factual findings rather than set them aside and allow the BVA to decide the question anew on remand.

While Congress chose not to replace the clearly erroneous standard of review, it did foreclose the application of this standard in ways inconsistent with the benefit-of-the-doubt rule. Also, Congress made it clear that the CAVC is not to routinely remand cases for new BVA fact-finding when the findings of fact before the court did not have sufficient support in the record and the current record supports a conclusion opposite of that reached by BVA. However, the CAVC has construed these amendments, intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit-of-the-doubt rule, as making no substantive change. The court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule as long as the court's scope of review retains the clearly erroneous standard. To ensure the CAVC enforces the benefit-of-the doubt rule, Congress should replace the clearly erroneous standard with a requirement that the CAVC will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Recommendation:

Congress should amend 38 U.S.C. § 7261 to provide that the CAVC will hold unlawful and set aside any finding of material fact that is not reasonably supported by a preponderance of the evidence.



Preservation of Informalities of VA Claims Process

"Exhaustion" Requirement Has No Place in Veterans Benefits Claims:

By refusing to consider points not specifically argued to the Board of Veterans' Appeals (BVA), the Court of Appeals for Veterans Claims (CAVC) has—contrary to congressional intent and the law—imposed formal pleading requirements upon Department of Veterans Affairs (VA) informal administrative claims process.

When Congress authorized judicial review of veterans' claims, one of its foremost concerns and intents was preservation of the informality of VA's administrative claims process under conditions in which the BVA's decisions would be subject to review by a court. Congress was very much aware of the danger that courts might attempt to impose formal rules of adversarial proceedings upon VA's informal claims process and therefore sought to prevent this adverse consequence. By imposing an exhaustion requirement upon veterans, the CAVC has, for its own expedience, largely ignored congressional intent, the law, and the unique nature and purposes of veterans' programs by doing the very thing Congress so carefully and clearly acted to forestall.

In its broader sense, the purpose of the doctrine of exhaustion of administrative remedies is to prevent parties from bypassing the available administrative processes to take their claims directly to the courts. It has been recognized that the exhaustion doctrine has four primary goals: (1) discourage flouting of the administrative processes created by Congress; (2) allow the administrative agency to apply its expertise, to exercise its discretion, and to correct its own errors; (3) aid judicial review by allowing the parties and the agency to develop the facts of the case in the administrative proceeding; and (4) promote judicial economy by avoiding needless duplication of actions and perhaps by avoiding the necessity for any judicial involvement. Clearly, the law does not allow a veteran to bypass the BVA and appeal an agency of original jurisdiction decision directly to the CAVC. As provided in 38 U.S.C. § 7261, under an appeal properly before it, the court "shall," "to the extent necessary to its decision and when presented ... decide all relevant questions of law, interpret constitutional, statutory, and regulatory provisions, and determine the meaning or applicability of the terms of an action by the Secretary ... hold unlawful and set aside decisions, findings ... conclusions, rules, and regulations issued or adopted by the Secretary, the Board of Veterans' Appeals, or the Chairman of the Board." Contrary to

this statutory provision, the CAVC refuses to address "all" relevant questions of law, etc., "presented" to it unless the veteran expressly raised and argued these points to the BVA. In requiring that the veteran have first raised a precise legal point or argument to the BVA, the court is not only violating § 7261, it is ignoring congressional intent and improperly shifting VA's obligations under the law to veterans.

Unlike judicial or more formal administrative proceedings where it is the responsibility of the parties to raise and plead all legal arguments and discover and present all material evidence, veterans are not expected to know and plead the legal technicalities of veterans' benefits. Veterans file simple claims forms with basic information, not detailed legal pleadings. Congress repeatedly stated its intent to preserve and maintain this informal process throughout the legislative history of its legislation to authorize judicial review. It is VA's legal obligation to assist the veteran in filing the claim and developing the evidence and to consider all relevant legal authorities and potential bases of entitlement regardless of whether they are expressly raised by the veteran. When a veteran appeals to the BVA and receives an unfavorable decision, the veteran has exhausted his or her administrative remedies. Any failure to fully develop the record, to fully explore all avenues of entitlement, or to apply all pertinent law is an error of omission by the BVA that the CAVC should address in its appellate review irrespective of whether the veteran knew of or raised the specific point before the BVA. Yet for its own purposes the CAVC refuses to consider points of argument that were not specifically raised before the BVA. By requiring veterans to know and expressly raise and argue all the complex legal points relevant to a claim, the CAVC shifts the government's obligations to veterans, imposes unnecessary formalities upon VA's administrative claims process, and fundamentally alters the nonadversarial, pro-veteran nature of VA proceedings. The court seems unable or unwilling to grasp the simple fact that in considering veterans' appeals it reviews a claims record, not a litigation record.

Congressional intervention is necessary to restore veterans' basic rights under the VA claims process. Congress should amend 38 U.S.C. § 7261. The phrase "without regard to any theory of issue preclusion or exhaustion" should be added between the words "presented" and "shall" at the end of section (a). This change would not disfavor VA because the CAVC

provides the agency an opportunity to respond to any legal argument presented by a claimant before it rules.

Recommendation:

Congress should amend 38 U.S.C. § 7261 to preclude judicial imposition of formal pleading requirements upon the VA claims process.



Court Facilities

Courthouse and Adjunct Offices:

The Court of Appeal for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

During the nearly 17 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. This court for veterans should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the court should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA general counsel staff, court practicing attorneys, and veterans service organization representatives to the court in one place. The court should have its own home, located in a dignified setting and with distinctive architecture that communi-

cates its judicial authority and stature as a judicial institution of the United States.

Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

Recommendation:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the CAVC.



COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

Authority to Review Changes to VA Schedule for Rating Disabilities:

The exemption of Department of Veterans Affairs (VA) changes to the rating schedule from judicial review leaves no remedy for arbitrary and capricious rating criteria.

Under 38 U.S.C. § 502, the Federal Circuit may directly review challenges to VA's rulemaking. Section 502 exempts from judicial review actions relating to the adoption or revision of the VA Schedule for Rating Disabilities, however.

Formulation of criteria for evaluating reductions in earning capacity from various injuries and diseases requires expertise not generally available in Congress. Similarly, unlike other matters of law, this is an area outside the expertise of the courts. Unfortunately, without any constraints or oversight whatsoever, VA is free to promulgate rules for rating disabilities that do not have as their basis a reduction in earning capacity. *The Independent Budget* veterans service organizations have become alarmed by the arbitrary nature of recent proposals to adopt or revise criteria for evaluating disabilities. If it so desired, VA could issue a rule that a

totally paralyzed veteran, for example, would only be compensated as 10 percent disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the Court of Appeals for the Federal Circuit (CAFC) should have jurisdiction to review and set aside VA changes or additions to the rating schedule when they are shown to be arbitrary and capricious or clearly violate basic statutory provisions.

Recommendation:

Congress should amend 38 U.S.C. § 502 to authorize the CAFC to review and set aside changes to the "Schedule for Rating Disabilities" found to be arbitrary and capricious or clearly in violation of statutory provisions.



Medical Care

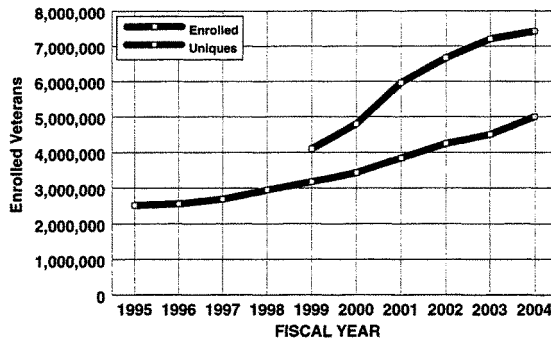
Medical Programs

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetics research. Additionally the VHA is the nation's primary backup to the Department of Defense in time of war or domestic emergency.

Of the 7.4 million enrolled veterans in fiscal year 2004, the VHA provided health care to more than 4.99 million of them. The quality of VHA care is equivalent to, or better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.

■ CHART 1. UNIQUE VHA PATIENTS & ENROLLED VETERANS

This graph shows the trend toward increasing the number of patients treated in VHA facilities and the increase of veterans enrolled for care.



Even though the Secretary of Veterans Affairs placed a moratorium on the enrollment of priority 8 veterans during FY 2003 that appears to have reduced the number of new enrollees, Chart 2 shows there has been no impact regarding the increasing number of patients treated in VHA facilities.

Although the VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and related health problems.

Year after year, the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past couple of years, *The Independent Budget* veterans service organizations (IBVSOs) are concerned about the methodology used in producing statistics reflecting this reduction in the backlog.

The annual shortfall in the VA Medical Care budget translates directly into higher national health-care expenditures. When veterans cannot get needed health-care services from VA, they go elsewhere, and the cost of care is shifted to Medicare or the safety net hospitals. In any case, society pays more while the veteran suffers. A method to ensure VA receives adequate funding annually to continue providing timely, quality health care to all enrolled veterans must be put in place.

For fiscal year 2005 (FY 2005), after rescissions, VA health care received an increase of \$992 million, far below *The Independent Budget* recommendation of more than \$3 billion. But this \$992 million figure is deceptive. After adjustments are made, including transfers and a shortfall attributed to VA's rosy yet wrong estimate of collections, the final amount of the FY 2005 increase is approximately \$480 million. Table 3, at right, which utilizes the VA's own figures, illustrates these adjustments. This amount does not even meet the mandated payroll increases for existing

employees, which VA estimated to be \$650 million in its FY 2005 budget submission, let alone begin to cover the cost of spiraling medical inflation and increased demand for health-care services. The actual budget impact of the final FY 2005 cost-of-living increase approved at the end of the year was more than twice the amount VA originally budgeted. In effect, the actual impact of the \$1.2 billion "increase" to improve VA health-care services was practically nullified. This funding shortfall will be made up through increased health-care rationing, longer waiting times for basic health care, and a further weakening of the health-care system devoted to the care of veterans.

TABLE 3

**FY 2005 Adjustments to FY 2005 Medical Care Appropriation Increase
(Dollars in millions)**

Medical Care Appropriation.....	+\$1,200
Collections	-466
Rescission	-228
VBA Transfer	-125
Hurricane Supplemental, P.L. 108-324	+124
Add-on for Medical Research	-21
Add-on for Inspector General	-5
Total Adjustments	+479

(Source: Department of Veterans Affairs)

Sadly, this increase was considered by many in Congress to be more than adequate. Over the years, VA has gone through periods of flat-lined budgets and budgets that fall far short of 13-14 percent annual increase VA itself identified it needed during testimony before a congressional committee, an increase that only reflects the amount needed to maintain current services.

Also complicating VA's ability to provide quality health care are threats to VA's ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P). A number of states and the District of Columbia have recently introduced legislation that would tie Medicaid drug prices to the FSS-P. Passage of federal legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing, since vendor contracts contain a clause allowing

the cancellation of these contracts in this event. Legislation has been previously introduced in Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P. Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL 101-508), has demonstrated that if these legislative initiatives are enacted VA's pharmaceutical costs would undoubtedly increase, harming both the VA health-care system and veterans.

Under the FSS-P, VA purchases on behalf of itself and other federal entities through contracts with responsible vendors approximately 24,000 pharmaceutical products at discounts ranging from 24 to 60 percent below drug manufacturers' most favored nonfederal, nonretail customer pricing. Since VA's pharmaceutical purchases are now roughly \$4 billion annually, the loss of these discounts would dramatically increase the costs of pharmaceuticals, as well as the cost of providing care, to an already underfunded health-care system. These added costs could also be passed on to veterans in the form of dramatically higher copayments.

Congress and the Administration need to address pharmaceutical cost-related issues in a manner that does not result in a reduction of veterans' benefits or threaten discounts VA currently receives under the FSS-P.

VA is the second largest financial supporter of education for medical professionals, after Medicare, and the nation's most extensive training environment for health professionals. As academic medical centers are under increasing financial pressures to reduce health-care professional training, VA has mitigated this gap by maintaining existing programs that train for VA and the nation. VA has academic affiliations with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. Last year, more than 87,000 health professionals were trained in VA medical centers. In addition to their value in developing the nation's health-care workforce, the affiliations bring first-rate health-care providers to the service of America's veterans. The opportunity to teach attracts the best practitioners from academic medicine and

brings state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA.

Programs initiated at VA have led to the development of new medical specialties, such as geriatrics, which focuses on care of the elderly. VA-based training along with psychiatry, pain management, and spinal cord injury medicine are addressing the needs of the nation as well as the needs of our veterans. VA is developing new programs using teams of health-care providers that provide specialized services to veterans, such as palliative care teams that provide care to patients at the end of life. VA trains health-care professionals in the total care of the patient because VA health care provides total care to eligible veterans.

The largest integrated medical care system in the world has a unique capability to translate progress in medical science to improvements in clinical care and the health of the population. VA research is clinically focused: 80 percent of VA researchers see patients. The patient focus keeps VA research relevant and provides the incentive to translate research findings into evidence-based medical practice. More effectively than any other federal research funding sector, the VHA provides a mechanism for the clinical application of research findings.

VA leverages the taxpayers' investment via a nationwide array of synergistic partnerships with the National Institutes of Health, other federal research funding entities, the for-profit sector, and academic affiliates. This extraordinarily productive enterprise demonstrates the best in public-private cooperation.

VA medical and prosthetic research is a national asset that is a magnet for attracting high-caliber clinicians to practice medicine in VA health-care facilities. The resulting atmosphere of medical excellence and ingenuity, developed in conjunction with collaborating medical schools and universities, benefits every veteran receiving care at VA and ultimately benefits all Americans.

Medical Care
(in thousands)

MEDICAL CARE (COMBINED ACCOUNTS)

FY 2005	\$27,699,395
FY 2006 Administration Request	27,810,684
FY 2006 <i>Independent Budget</i> Recommendation.....	31,226,998

(excludes MCCF)

MEDICAL SERVICES

FY 2005	\$19,316,995
FY 2006 Administration Request	19,995,141
FY 2006 <i>Independent Budget</i> Recommendation.....	22,486,154

FY 2006 Recommendation (in thousands)

Current Services Estimate	\$20,303,749
Enroll Priority 8 Veterans	415,497
Increased Demand	1,266,908
Improve Specialized Services and Programs	500,000
<i>Total, FY 2006 Recommendation</i>	\$22,486,154

MEDICAL ADMINISTRATION

FY 2005	\$4,667,360
FY 2006 Administration Request	4,517,874
FY 2006 <i>Independent Budget</i> Recommendation.....	4,866,036

MEDICAL FACILITIES

FY 2005	\$3,715,040
FY 2006 Administration Request	3,297,669
FY 2006 <i>Independent Budget</i> Recommendation.....	3,874,808



MEDICAL CARE ACCOUNT

Adequate Funding for VA Health Care Needed

The Department of Veterans Affairs (VA) must receive adequate funds to meet the ever-increasing demands of veterans seeking health care.

Once again this year, VA faces a critical situation in funding for health care. Ever-increasing demand on the system coupled with inadequate resources provided after the start of the new fiscal year (FY) has placed enormous stress on the system and has left VA struggling to provide the care that veterans have earned and deserve.

For fiscal year 2005 the Administration requested an increase of only \$310 million in appropriated dollars, a mere 1.2 percent increase over the FY 2004 level. This was the lowest appropriation request for VA health care made by any administration in nearly a decade. The Administration chose to use budget gimmicks, higher out-of-pocket costs for veterans (including a proposed \$250 user fee for category 7 and 8 veterans and increased copayments), and major cuts in long-term care programs as a substitute for requesting real dollars. VA has also chosen to continue to deny enrollment to new category 8 veterans as a cost-saving measure.

In contrast, *The Independent Budget* recommended \$29.8 billion for veterans health care for FY 2005, a \$3.2 billion increase over FY 2004. This amount represents the cost to provide care not only for all veterans currently seeking care from VA but also for veterans who were denied care by VA last year. The House and Senate Committees on Appropriations provided a \$1.2 billion increase (before rescission) over the budget request, the same amount as VA Secretary Anthony Principi requested from the Office of Management and Budget (OMB). This increase would fall short of *The Independent Budget* recommendation as well as the 13–14 percent annual increase that VA has testified it needs to simply maintain the same level of services as the previous year.

The VA funding crisis is exacerbated by Congress not passing the VA, HUD, and Independent Agencies appropriations bill prior to the start of the new fiscal year on October 1, 2004. Unfortunately, failing to provide a VA budget on time is becoming an annual event. In the past five fiscal years, VA has not received its appropriation before the start of the new fiscal year. In the past two years, the appropriation was not

enacted until after January 1 of the next year—more than one-third of the way through the new fiscal year.

The inadequate increase VA received in the omnibus spending bill for FY 2005 was not received in a timely manner, thus preventing VA from properly planning to meet the needs of veterans and from effectively competing to hire nurses, doctors, therapists, and other health-care professionals. The omnibus spending bill may also force VA to make difficult decisions about providing certain services to certain veterans, such as canceling or postponing surgeries for non-life-threatening conditions because resources are not available to perform the procedures.

Faced with growing federal budget deficits, there will be increased pressure to reduce discretionary spending in all federal programs, including VA health care. Earlier this year, Congress considered budget control legislation that would have placed spending caps on all discretionary programs. These caps would have meant real cuts in funding. Likewise, VA faces the possibility of a reduction in funding beginning next year. News reports earlier in 2004 indicated the OMB had requested that VA identify \$900 million in cuts in discretionary spending, primarily from health-care funding. Such a cut would likely force VA to further restrict enrollment of new veterans seeking access to the system and could mean staff cuts, which would result in longer wait times for veterans. Yet, as these events are taking place, opinion polls show that the majority of Americans believe that veterans' health care should be a high funding priority in the federal budget.

VA is also dealing with increased demand as it provides care to sick and disabled veterans returning from Iraq and Afghanistan. By law, VA is required to provide "hospital care, medical services, and nursing home care for any illness" determined to be service connected for these returning service members for a period of two years.

The Independent Budget veterans service organizations believe that without adequate resources veterans will

continue to face health-care rationing, longer wait times for basic health-care services, and lower quality care. To that end, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. This would not create a new entitlement; rather, it would change the manner of health-care funding, removing VA from the vagaries of the appropriations process. Until this proposal becomes law however, Congress and the Administration must ensure VA is fully funded through the current process.

As the number of new veterans seeking health care continues to grow, and VA continues to care for veterans of prior conflicts, we must ensure that VA provides the quality health care that our veterans have earned with their service and their sacrifices.

Recommendation:

Congress and the Administration must provide adequate and timely funding for veterans' health care to ensure that VA can provide the necessary services to veterans seeking care.



MEDICAL CARE ISSUES

Accountability

Accountability is sadly lacking throughout much of the Veterans Health Administration (VHA) with respect to clearly prescribed objectives and goals and well-defined, enforceable outcomes.

The Independent Budget veterans service organizations (IBVSOs) continue to emphasize the importance of providing adequate funding for the Department of Veterans Affairs (VA) medical care on a timely basis. This is paramount toward ensuring the VHA's ability to deliver high-quality and accessible services to veterans. Even so, it is also evident that simply providing additional dollars, in and of itself, is not enough to achieve much needed enhancements to operational efficiency and effectiveness in the VHA.

Accountability—with respect to clearly prescribed objectives and goals and defined, enforceable outcomes—is sadly lacking throughout much of the VHA. It is in this crucial area that the IBVSOs insist upon much greater focus and, ultimately, meaningful improvement.

In this regard, it is evident that past and present VHA Under Secretaries have not been successful in establishing and institutionalizing common purposes and goals, creating measurements with common indices to monitor progress, demanding accountability, and promoting more efficient and effective provision of health care to veterans. It is now time for the establish-

ment of a corporate culture of accountability throughout the VHA.

Concurrently, to make management structure and function more effective within the VHA, individual managers—from the Office of the Secretary to a community-based outpatient clinic office manager—must be held individually responsible for their areas of operation. Performance appraisals and senior employment contracts must accurately reflect execution in achieving specific outcomes. Success should be fittingly rewarded and failure appropriately penalized.

Essential here is that management be provided with the requisite tools to enforce performance standards among the personnel under their direction. They must be able to create an environment that promotes superior service, discourages mediocrity, and precludes substandard performance.

Achieving accountability within the VHA will directly contribute toward providing greatly enhanced health-care services to veterans within the context of finite budgetary resources. Individual managers must be held responsible for their areas of operation so

performance appraisals and senior employment contracts accurately reflect execution in achieving specific outcomes. The VHA must develop and enforce meaningful performance standards and reward those individuals who exceed these standards and take appropriate measures with those whose performance is substandard or unacceptable. Management must be provided with all the requisite tools to enforce performance standards among the personnel under their direction.

Recommendations:

The VHA must develop and enforce meaningful performance standards. The VHA should then reward those individuals who exceed the standards and properly penalize those whose performance is substandard or unacceptable.

VHA management must be provided with the requisite tools to enforce performance standards among the personnel under their direction.



Guaranteed Full Funding for VA Health Care

Congress should enact legislation that will guarantee a reliable, predictable funding stream for veterans' health care so that enrolled veterans have access to high quality and timely health-care services.

Each year *The Independent Budget* veterans service organizations (IBVSOs) fight for sufficient funding for Department of Veterans Affairs (VA) health care and a budget that is reflective of the rising cost of health-care and increasing need for medical services. Despite our continued efforts, year after year funding provided under the current discretionary funding mechanism falls short of what is needed to provide quality health-care services in a timely manner to our nation's sick and disabled veterans. The amount of discretionary funding provided to VA for veterans' health care is determined by political processes and, unfortunately, based more on political considerations than funding needs. To make matters worse, for the past six years Congress has not enacted the VA budget at the start of the fiscal year. The lack of a consistent and reliable budget process has prevented VA from adequately planning for and meeting the growing needs of veterans seeking health care. Clearly, the current funding mechanism for veterans' health care is broken and in need of reform. We believe direct/guaranteed full funding for VA health care is a comprehensive and reasonable solution to address these serious problems.

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veter-

ans (PTF or task force). The task force was charged to identify ways to improve health-care delivery to VA and Department of Defense (DOD) beneficiaries. Of most importance to the IBVSOs is the task force's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its final report that "it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DOD but, if unresolved, will delay veterans' access to care and could threaten the quality of VA health care." The IBVSOs believe the cumulative effects of insufficient, inflation-eroded appropriations for health-care funding, coupled with a significantly increased demand for care, have already had a negative impact on VA health-care delivery and have resulted in the severe rationing of medical care. As a solution to this complex problem, the PTF recommended the government provide full funding for VA health care for priority groups 1-7 by using a mandatory funding mechanism or by some other changes in the process that achieve the desired goal to ensure enrolled veterans are provided the current comprehensive benefits package in accordance with VA's established access standards. The PTF also suggested the government address the present uncertain access status and funding of priority group 8 veterans.

The PTF's final report noted that the discretionary appropriations process has been a major contributor to the historic mismatch between available funding and demand for health-care services. We agree that to improve timely access to health care for our nation's sick and disabled veterans, the federal budget and appropriations process must be modified to ensure full funding for the veterans health-care system. The long-term solution must factor in how much it will cost to care for each veteran enrolled in the system and a guarantee that the full amount determined will be available to VA to meet that need. Including priority group 8 veterans under a guaranteed full funding mechanism is essential to ensuring viability of the system for its core users, preserving VA's specialized programs, and maintaining cost effectiveness.

Even though Congress has increased discretionary appropriations for veterans' health care in the recent past, funding levels have simply not kept pace with medical care inflation or the significant increase in demand for services. VA has seen a 134 percent increase in the number of enrolled veterans from 1996 to 2004. Unfortunately, VA health-care funding has increased only 60 percent over the same period. On average, VA has received only a 5 percent increase in appropriations over the past eight years. VA has testified that—at a minimum—a 14 percent increase is needed annually for medical care just to maintain current services.

The IBVSOs firmly believe that our nation's veterans have earned the right to medical care through their extraordinary sacrifices and service to this nation. We believe VA has an obligation to provide veterans timely top quality health care and that Congress has an obligation to ensure that VA is provided sufficient funding to carry out that mission. We agree that the real problem, as the PTF aptly states in its report, is that "the Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions."

In response to the VA health-care funding crisis and the PTF's report, nine veterans service organizations formed the Partnership for Veterans Health Care Budget Reform in support of direct/mandatory funding for VA health care. The partnership is composed of The American Legion, AMVETS (American Veter-

ans), Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Heart of the U.S.A., Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, and the Vietnam Veterans of America.

During the 108th Congress, mandatory funding bills were introduced in both chambers. The Assured Funding for Veterans Health Care Act of 2003 was introduced in the House of Representatives as H.R. 2318, and in the Senate as S. 50. H.R. 2318 would have, in FY 2005, made available to VA 130 percent of the amount obligated during FY 2003. The amount would continue to be adjusted in the following fiscal years based on the number of enrolled veterans and the number of persons eligible but not enrolled who are provided care, multiplied by the per capita baseline amount for FY 2003, as increased by the percentage increase in the Hospital Consumer Price Index. Unfortunately, neither of these measures was enacted.

Additionally, in the last session of the 108th Congress, the Senate considered an alternative funding plan in the form of an amendment to resolve VA's health-care funding crisis. The amendment called for a combination of direct and discretionary funding. The discretionary funding level would have remained at the FY 2004 level with the direct funding level based on the formula contained in H.R. 2318 less the amount of discretionary funding. Unfortunately, the amendment was defeated—even with full support of the Partnership for Veterans Health Care Budget Reform.

We believe it is disingenuous for our government to promise health care to veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our nation and continue to carry the physical and mental scars of that service. Providing direct funding for veterans' health care would eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the needs of the constantly growing number of veterans seeking treatment. It would also provide Congress the ability to continue its fiscal oversight of VA health-care programs.

We propose to simply shift funding for VA health care from discretionary appropriations to direct funding so that all eligible veterans enrolled in the VA health-care system have timely access to VA medical programs and services currently provided under title 38, United States Code. This will guarantee full funding for VA health care even when Congress cannot pass timely appropriations bills and will alleviate the need for continuous debate in Congress each year. We believe this will also stop the severe rationing of health care that is typical of today's veterans' health-care system.

Guaranteed full health-care funding would not create an individual entitlement to health care nor change VA's current mission. We do not propose to change the existing eligibility criteria for priority groups 1 through 8 or the medical benefits package defined in current regulations, only how funds are provided for VA health care. Having a sufficient number of veterans in the health-care system is critical to maintaining the viability of the system and sustaining it into the future. By including all veterans currently eligible and enrolled for care, we protect the system and the specialized

programs VA has developed to improve the health and well-being of our nation's sick and disabled veterans.

Veterans expect the federal government to honor its commitment and obligation to those who previously served in the armed forces and to those who are currently serving in Iraq and Afghanistan and fighting the war on terror in other parts of the world. Our nation's sick and disabled veterans cannot wait any longer for the government to take action. Now is the perfect opportunity for Congress to move forward on the recommendations of the PTF, charged with improving health-care delivery for our nation's veterans, and to support a permanent solution to resolve this untenable situation.

Recommendation:

Congress should enact legislation that would shift funding for VA health care from discretionary appropriations to direct funding so that all eligible veterans enrolled in the VA health-care system have timely access to VA medical programs and services currently provided under title 38, United States Code.



Homeland Security/Funding for the Fourth Mission

The Veterans Health Administration (VHA) is playing a major role in homeland security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.

The Department of Veterans Affairs (VA) has four critical health-care missions. The primary mission is to provide health-care to veterans. VA's second mission is to educate and train health-care professionals. The third mission is to conduct medical research. VA's fourth mission is, as a Government Accountability Office report stated in October 2001, to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

VA has statutory authority, under 38 U.S.C. § 8111A, to serve as the principal medical-care backup for military health care "[d]uring and immediately following a

period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks on September 11, 2001, the president signed into law an "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

As part of its fourth mission, VA also has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System

(NDMS), created by P.L. 107-188 (the "Public Health Security and Bioterrorism Preparedness Response Act of 2002"), has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters, including natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including weapons of mass destruction events, in accordance with the National Response Plan. The NDMS is a partnership between the Department of Homeland Security, VA, the DOD, and the Department of Health and Human Services. According to the VA Web site (www.va.gov), some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each veteran integrated service network to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to those individuals affected by terrorist activities.

Also in 2002, P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act of 2002," was enacted. This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and development of methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary, or other explosive weapons or devices posing threats to the public health and safety; education, training, and advice for health-care professionals; and laboratory, epidemiological, medical, and other appropriate assistance for federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. These centers, although authorized by law, have not received funding.

VA has been spending ever-increasing sums to attempt to meet its fourth mission requirements. During a hearing before the House Committee on Veterans' Affairs on August 26, 2004, VA testified that its funding for medical emergency preparedness rose from

\$80.3 million in fiscal year 2002 (FY 2002) to \$257.3 million in FY 2004. VA also stated that it requested \$281 million for FY 2005. Unfortunately, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. This funding is simply drawn from the medical care account, providing VA with fewer resources with which to meet the health-care needs of veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that VA lacks the resources to meet its fourth mission responsibilities. Without sufficient funding, VA has drawn resources away from other critical programs to accomplish this mission. VA has many responsibilities to meet, and it will strive to meet these responsibilities, but if sufficient funding is not provided, scarce resources will be diverted from direct health-care services.

The fourth mission allows the Secretary of Veterans Affairs to furnish medical care to active duty military personnel. However, there is a caveat, in that the Secretary may not allow the military to receive a higher priority for medical treatment than that of service-connected disabled veterans. Unfortunately, if the fourth mission must be utilized, a large number of VHA medical professionals will not be available, as they will, quite probably, have been mobilized as members of the reserve components of the armed forces. According to former Under Secretary for Health Robert Roswell, these may include 482 physicians, 172 dentists, 2,209 registered nurses, 3,259 in other medical fields, and 7,144 men and women in support roles. If these 13,266 VHA employees are, in fact, called up with reserve forces, how does VHA support its fourth mission?

Public Law 107-188 directs that "The Secretary of Veterans Affairs shall take appropriate actions to enhance the readiness of Department of Veterans Affairs medical centers to protect the patients and staff of such centers from chemical or biological attack or otherwise to respond to such an attack and so as to enable such centers to fulfill their obligations as part of the Federal response to public health emergencies... (To) include (A) the provision of decontamination equipment and personal protection equipment at Department medical centers; and (B) the provision of training in the use of such equipment to staff of such centers."

The Secretary must also ensure that not only staff, but patients as well, are protected in event of an emergency, whether chemical, biological, or another type of terrorist attack. Additionally, there are security and pharmacology issues addressed by P.L. 107-188, as well as training issues under the cognizance of the Public Health Service Act (Title 42 United States Code), that need to be addressed. public law 107-188 authorized an appropriation of \$133 million for VA to fulfill the added responsibilities in FY 2002. For the next four fiscal years, VA has been authorized to have appropriated "...such sums as may be necessary."

Additionally, the successful implementation and performance of the fourth mission requires the VA to have the proper facilities. In 1986, the Assistant Secretary of Defense for Health Affairs testified before the House Committee on Armed services that "VA was directed to serve as the primary backup to the DOD in the event of a war or national emergency. The two Departments have made great strides in designing a VA backup system to our contingency system at DOD. Today the system stands ready to provide 32,506 contingency beds for use by DOD in the event of a war or a national crisis."

However, the General Accountability Office reported (GA0-02-145T) on October 15, 2001, that "VA has plans for the allocation of up to 5,500 of its staffed operating beds for DOD casualties within 72 hours of notification...VA's plans would provide up to 7,574 beds within 30 days of notification."

This is a decrease of 77% of available beds in the intervening 15 years. Looking through the Draft National Critical Asset Realignment for Enhanced Services plan, it appears that the VHA may be giving up an additional 4,441 beds, of which 666 would come out of the DOD Contingency Plan; thus we have a total loss, since 1986, of an estimated 79% of the DOD contingency beds.

VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. These important roles once again point out the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services. The IBVSOs do not believe VA currently has the resources nor the ability it needs to adequately care for veterans, much less those needed to complete its fourth mission. If VA is to fulfill its responsibilities, it must be provided these resources.

Recommendations:

Congress should provide funds necessary in the VHA's FY 2006 appropriation to fund the VA's fourth mission.

Funding for the fourth mission should be included in a separate line item in the Medical Care Account.

Congress and the Administration should provide the funds necessary to establish and operate the four emergency preparedness centers created by P.L. 107-287.

Seamless Transition from the DOD to VA

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) must ensure that servicemen and women have a seamless transition from military to civilian life.

As service members return from the wars in Iraq and Afghanistan, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service and become veterans. Currently, transition from the DOD to VA is anything but seamless, and undue hardship is placed on new veterans trying to gain access to VA. *The Inde-*

pendent Budget veterans service organizations (IBVSOs) believe veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The Independent Budget supported the recommendations of the report of the President's Task Force to

Improve Health Care Delivery for Our Nation's Veterans (PTF), released in May 2003, regarding transition of soldiers to veteran status. The PTF stated that "providing these [veterans] timely access to the full range of benefits earned by their service to the country is an obligation that deserves the attention of both VA and the DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed."

An important recommendation of the PTF was the subject of a letter sent last year to VA Secretary Anthony Principi and Defense Secretary Donald Rumsfeld. Specifically, we believe the DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. These electronic medical records should also include an easily transferable electronic form DD 214 (Certificate of Release or Discharge from Active Duty) forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The Departments have each taken positive steps to share data from their health information systems. The Federal Health Information Exchange initiative and the pharmacy data project are steps in the right direction. However, obstacles remain that will hinder the momentum of progress made toward the goal of a bidirectional health information exchange by next year.

The Chairmen and Ranking Members of the House Veterans' Affairs and Armed Services Committees sent letters last year to Secretary Principi and Secretary Rumsfeld, expressing concern with the current transition of servicemen and women. The letter stated that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurred with the PTF recommendation that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." This would enhance collaboration by the DOD and VA to identify, collect, and maintain the

specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

We have expressed support for the Disabled Soldier Support System (DS3) implemented by the Department of the Army and the Disabled Marine Support System (DMS2) by the Department of the Navy in 2004. These programs' responsibilities are to assist the most severely injured service members and their families in transition from military to civilian life. Currently, the programs have limited staffing, with a limited budget to assist these veterans. *The Independent Budget* supports legislation to authorize additional funding for the DS3 and DMS2 programs and allow DOD to expand them to address more service member's needs. With a high number of severely injured soldiers and Marines returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance this successful program.

The IBVSOs believe the men and women exiting military service should be afforded easy access to the health care and benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

The DOD and VA must ensure that servicemen and women have a seamless transition from military to civilian life.

The DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for two-way electronic exchange of health information and occupational and environmental exposure data. The records should also include an electronic form DD 214.

The DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process.

Congress and the Administration must provide additional funding for the DS3 program to allow the DOD to expand this program so that it can address the needs of more seriously disabled soldiers.

CARES Impact on Long-Term Care and Mental Health Services

The Independent Budget veterans service organizations (IBVSOs) believe mental health services and long-term care are part of the full continuum of care for veterans and should not be excluded from the Capital Asset Realignment for Enhanced Services (CARES) process.

The Secretary of the Department of Veterans Affairs (VA), on May 7, 2004, made a comprehensive, multifaceted decision on a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through the CARES project, in February 2002 and ongoing, VA is evaluating the demand for health-care services and identifying changes that will help meet veterans' current and future health-care needs. By its very nature, CARES is a complex process that involves the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the current supply and identification of current and future gaps in infrastructure capacity. This eventually resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure. Subsequently, the Secretary established a commission to review the entire CARES plan and to provide recommendations on the realignment of mission and facilities.

Since publication of *The Independent Budget for Fiscal Year 2005*, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The VA Secretary formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, we note, the DNCP market plans did not include any projections for mental health services or long-term care. The commission, however, recognized the importance of mental health services and long-term care to the veteran population and stated, in part, that "in reviewing the early projections for CARES, VA realized that it needed to make modification to its projections for outpatient, acute inpatient, and long-

term psychiatric mental health care programs." The commission acknowledged that VA is currently making adjustments to these models and recommended that when complete, the forecast be rerun, that gaps in service be identified, and that VA plan to address those gaps. It also recommended that VA take action to ensure consistent availability of mental health services across the system, to provide mental health care at community-based outpatient clinics, and to collocate acute mental health services with other acute inpatient service wherever feasible.

The commission also provided several recommendations for VA to address long-term care while implementing the CARES program. The main recommendation was that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for seriously mentally ill veterans." Moreover, the commission recommended the plan should include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model.

The IBVSOs concur with the CARES Commission's recommendations on mental health-care services and long-term care. It is our contention that mental health services and long-term care are part of the full continuum of care for veterans and should not be excluded from the CARES process.

Recommendation:

VA, in implementing the CARES plan, must ensure that mental health services and long-term care are part of the full continuum of care for veterans.



Inappropriate Billing

Service-connected veterans and their insurers are constantly frustrated by inaccurate and inappropriate billing for services related to conditions secondary to their service-connected disability.

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports of veterans with service-connected amputations being billed for the treatment of associated pain and of veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers continue to surface. Inappropriate billing for secondary conditions forces veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden both to veterans and an already backlogged claims system.

Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly due to VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the Veterans Benefits Administration (VBA) and the VHA.

VA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly information about service-connected conditions that exceed

the six stored in the C&PBDN. According to VA, difficulties in the development and implementation of step two have delayed the action plan for improving VBA-VHA sharing of information about veterans' service-connected conditions.

VA acknowledges that because of data integrity not all cases with more than six service-connected conditions have been identified under the new plan. While continued improvements to the VBA database are being made, VA will be reviewing and validating the results prior to establishing a routine monthly update to provide complete service-connected disability information.

Recommendations:

The Under Secretary for Health should firmly establish and enforce policies that prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that relate to an original service-connected disability rating.

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the C&PBDN master record.



Appropriations, Not MCCC

Third-party payments should augment, not offset, the Department of Veterans Affairs (VA) medical care appropriation.

The fiscal year 2006 *Independents Budget* calls for an adequate medical care budget fully funded by appropriations. Therefore, we strongly oppose the budget maneuver that Congress and the administration have used since 1997 to offset appropriations by the estimated amount that VA might collect from veterans and their third-party insurers.

VA is pursuing additional revenue sources and improved collections, and more revenue from these sources could improve access to care within VA. Many VA beneficiaries, especially priority 7 and 8 veterans, are Medicare-eligible. However, the Centers for Medicare and Medicaid Services is prohibited by law from reimbursing VA.

Potential sources of increased VA revenue are (1) improved collections from first-and third-party payers; (2) enhanced sharing with appropriate civilian community providers; (3) enhanced-use leases (for buildings or land where federal-civilian partnering can occur); and (4) reimbursement from other agencies when veterans are eligible for services from such agencies.

Developing additional revenue sources, whether from TRICARE reimbursements or Medicare subvention, will not help VA's overall funding situation if the additional revenues are simply applied as an offset to the department's budget request. VA could have a strong incentive to earn and collect additional revenues if it could retain these additional revenues without an offset to its appropriated budget.

The Independent Budget veteran service organizations (IBVSOs) believe it is the responsibility of the federal

government to fund the cost of veterans' care. Therefore, we have not included any cost projections for the Medical Cost Collection Fund (MCCF) in our budget development. VA's historical inability to meet its collection goals has eroded our confidence in the Veterans Health Administration estimates. We also object to funding the absurdly high cost of collections out of the veterans' medical care account. The IBVSOs believe the cost of implementing effective billing practices and systems will absorb any net income generated by the MCCF.

Recommendation:

The Administration and Congress must base the VA medical care budget on the principle that third-party collections are to supplement, not substitute for, appropriations.



Waiver of Health-Care Copayments and Fees for Catastrophically Disabled Veterans

Veterans in priority group 4 should not be subject to copayments.

Under current law, veterans who meet the definition of having catastrophic disabilities as a result of non-service-connected causes and who have incomes above means-tested levels can still enroll in the Department of Veterans Affairs (VA) as priority 4 veterans instead of the less preferential categories 7 and 8. This heightened priority for VA health-care eligibility was granted in recognition of the unique nature of these disabilities and the need for these veterans to avail themselves of the complex specialized health-care services which are, in many instances, unique to the mission of the VA health-care system. The higher, priority 4, enrollment category would also protect these veterans from having access to the system denied were they, under usual circumstances, to be considered in the lower priority category 7 or 8 if VA health-care resources were to be curtailed.

However, current VA regulations stipulate that even though these veterans are to be considered priority 4

for the purpose of enrollment due to their specialized needs, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category. This interpretation violates the intent of the statute in recognizing the unique needs of these veterans and the role of the VA in providing their care. It also puts great financial hardship on these catastrophically disabled veterans who need to use far more VA health-care services at a far greater extent than the average VA health-care user. In many instances, fees for medical services equipment and supplies can climb upwards to thousands of dollars per year.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and

other federal and state support systems. In so doing they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet when a veteran's industry and employment brings annual income above the means-test levels, he or she is unduly penalized by exorbitant fees. This "catch-22" status does little to reward or provide an incentive for a highly disabled veteran to maintain employment and a productive life.

Recommendation:

Veterans designated by VA as being catastrophically disabled for the purpose of enrollment in health-care eligibility category 4 should be exempt from all health-care copayments and fees.



Access Issues

While the Veterans Health Administration (VHA) has made commendable improvements in quality and efficiency, veterans' access to their health-care system is severely limited. Excessive waiting times and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

Advanced Clinic Access Initiative

Veterans have to wait too long for appointments.

Access is the primary problem in veterans' health care. The significant backlog of delayed appointments, which is caused by severe funding shortfalls, is the immediate cause of veterans' limited access. Many Department of Veterans Affairs (VA) facilities and clinics have reached capacity and have had to limit enrollment. Due to perennially inadequate health-care budgets, the VA health-care system can no longer meet the needs of our nation's sick and disabled veterans. Without funding for increased clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services.

A July 2002 survey by the VHA revealed more than 310,000 veterans waiting for medical appointments, half of whom must wait six months or more for care and the other half having no scheduled appointment. VHA now reports the national total of veterans who will likely wait six months or more for nonemergent clinic visit has been reduced from 43,217, on October 15, 2003, to 22,077 as of September 1, 2004. Also, over the same period, the number of veterans waiting for their first appointment to be scheduled (audiology, primary care, cardiology, eye care, orthopedics, and

urology) was reduced from 17,496 to 4,957. VA also reported 25,775, veterans waiting for a follow-up appointment.

Last year the situation became so critical that the Secretary of Veterans Affairs instituted regulations to allow the most severely disabled service-connected veterans priority access in the VA health-care system. Though caring for veterans with service-connected disabilities is a core commitment for VA, these actions do not provide timely access to quality health care for all eligible veterans authorized access to VA health care under the provisions of the Health Care Eligibility Reform Act of 1996. To ensure that all service-connected disabled veterans and all other enrolled veterans have access to the system in a timely manner, it is imperative that our government provide an adequate health-care budget to enable VA to serve the needs of disabled veterans nationwide.

The Advanced Clinic Access Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing health-care demand, has shown promise in addressing the issue of

waiting times. The goal is to build a system in which veterans can see their health-care providers when needed. Through the work of a few leaders, this program reduced average waiting times and significantly improved veterans' access to their health-care system as measured in 2002 and 2003.

In 2004, 94 percent of primary care patients and 93 percent of specialty care patients were able to schedule an appointment within 30 days of their desired date despite increased demand. Although VA states that this is an improvement from 2003, this measurement is not equivalent to that used in 2002 and 2003 when veterans' access to care was measured by the average number of days they had to wait for treatment. The change in measuring veterans' access to care reflects VA's struggle on how to best capture and measure the veterans' experience in seeking VA health care with rudimentary impediments, such as a cumbersome scheduling software package.

Despite any measurable improvements in waiting times for needed appointments, continued disparities exist in the implementation of the Advanced Clinic Access Initiative nationwide. With a growing number of volunteer coaches who serve as consultants and trainers, and growing support from Veterans Integrated Service Networks (VISNs) and facilities, success is largely dependent upon the availability of

funding. Furthermore, only one dedicated full-time employee and one half-time employee manage the Advanced Clinic Access Initiative. A fully staffed and supported Advanced Clinic Access initiative could develop better ways to properly measure waiting times, link performance measures to improvements in waiting times, and compare VHA patients' waiting times with those of private sector patients.

Both increased medical care appropriations and VA's Advanced Clinic Access Initiative are needed to improve veterans' access to VA health-care services.

Recommendations:

VISNs and facility directors should evaluate whether veterans as well as the clinics in their area would benefit from the Advanced Clinic Access Initiative.

The VHA should provide adequate funding for successful implementation of the Advanced Clinic Access Initiative to measurably improve waiting times.

The VHA should include improvements in waiting times as part of an administrator's performance measures.

VA should establish a physician-led program within VHA national headquarters and provide six full-time staff to the Advanced Clinic Access Initiative.



Community-Based Outpatient Clinics

Many community-based outpatient clinics (CBOCs) do not comply with the Americans with Disabilities Act and lack staff and equipment to serve the specialized needs of veterans.

As of July 2004, the Veterans Health Administration (VHA) operated 691 community-based outpatient clinics. Additionally, contained in the Secretary's Critical Asset Realignment for Enhanced Services decision (May 2004) is establishment of 156 priority CBOCs by 2012, pending availability of resources and validation with the most current data available. *The Independent Budget* veterans service organizations (IBVSOs) commend the VHA's efforts to expand access to needed primary care services. For many veterans who

live long distances from VA medical centers (VAMCs), and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to, and shorten waiting times for, follow-up care.

While we support establishment of CBOCs, we remain concerned that they often fail to meet the needs of

veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff. Nor do they necessarily improve access to specialty health care for either the general veteran population or for those with service-connected mental illness. In that connection, to VA's credit, the revised criteria for establishment of CBOCs includes the availability of mental health services. Moreover, too often CBOC staff lack the requisite knowledge to properly diagnose and treat conditions commonly secondary to spinal cord dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care program. Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with Section 504 of the Rehabilitation Act (29 U.S.C. §791 et seq.) regarding physical accessibility to medical facilities. Veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the accomplishment of the VHA's mission of providing health services to veterans with specialized needs. These individuals also require primary and preventive care, which in many cases can be appropriately provided in CBOCs. It is essential, however, that CBOCs use clinically specified referral

protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

To ensure the integrity of the VA medical system, it is essential that Congress and the Administration appreciate the indispensable role of VAMCs in providing both acute and primary care. The IBVSOs are concerned that valuable resources will be siphoned away from the infrastructure of VA hospitals as more CBOCs are established. Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VHA care.

Recommendations:

The VHA must ensure CBOCs are staffed by clinically appropriate providers capable of meeting the special health-care needs of veterans wherever those needs justify specialized resources.

The VHA must develop clinically specific referral protocols to guide patient management in cases where a patient's condition calls for expertise or equipment not available at the facility at which the need is recognized.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in Section 504 of the Rehabilitation Act.



Veterans Rural Access Hospital (Critical Access Hospital)

Many community based outpatient clinics (CBOCs) are being redesignated as critical access hospitals.

Last year, *The Independent Budget* veterans service organizations (IBVSOs) recommended that further data be obtained to support various Capital Asset Realignment for Enhanced Services (CARES) recommendations that would close or change the mission of certain small or rural Department of Veterans Affairs (VA) facilities. The CARES Commission also recommended that VA establish a clear definition and clear

policy on the critical access hospital designation prior to making decisions on the use of this designation.

Accordingly, VA is currently developing a policy to define the appropriate scope of services that should be provided at small and rural facilities. The Veterans Rural Access Hospital (VRAH) policy, specifically, will define the clinical and operations characteristics of small and rural facilities within VA.

Our concern is whether VA's new VRAH policy considers the implications referrals will have on providing quality health care in a timely manner, particularly at other medical centers within a Veterans Integrated Service Network. VA must also consider patient satisfaction in the criteria they use for determining which facilities will retain acute-care services. If acute-care beds are to remain in one facility because of distances that veterans must travel to access inpatient services, the same logic should be used systemwide. For example, a decision was made to retain the inpatient care mission at the Cheyenne VA Medical Center because the medical center is more than 100 miles from the nearest VA medical center (Denver), and the closest private hospital that is joint commission accred-

ited is more than 60 minutes away. Another decision was made to close inpatient medical services at Ft. Wayne, Indiana, and Kerrville, Texas, and refer patients well over a hundred miles to other VA facilities without recognizing the inconvenience to the veteran and the potential impact that the closure would have on area hospitals and other VA facilities workload.

Recommendation:

VA must ensure that the distances veterans must travel to obtain inpatient medical and surgical services be considered before determining the appropriate location for providing these services.

VHA-DOD Sharing

The Independent Budget encourages collaboration of Department of Veterans Affairs and the Department of Defense (VA-DOD) health care and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. Federal law (38 U.S.C. § 8111(a)) states: "The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly [.]"

However, there appears to be a number of gaps in what is required by statute and what actually occurs. In a report released in January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance addressed the need for greater sharing between the VHA and DOD. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), created by Executive Order in May 2001, was asked to:

- "identify ways to improve benefits and services for VA beneficiaries and DOD military retirees

who are also eligible for benefits from VA through better coordination of the two departments;

- review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and
- identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure."

The Capital Asset Realignment for Enhanced Services (CARES) Commission report of February 12, 2004, states: "Over the past decade, a number of commissions, advisory organizations, and the General Accounting Office [currently the General Accountability Office] have studied various approaches to providing quality health care to veterans. One of the recurring recommendations to fulfill this obligation has been to improve collaboration and sharing between VA and DOD."

It is time that we stop doing studies, writing reports, and taking minimal action. It has become imperative that in this time of tight funding and a war against world terrorism, we begin implementing many of the recommendations made by these various reports, as well as take further actions to foster VHA-DOD sharing.

The IBVSOs continue to support the careful expansion of VHA-DOD sharing agreements. However, we concur with the statement of Dr. C. Ross Anthony (one of the PTF commissioners) before the House Committee on Veterans' Affairs in June 2003, when he said that the PTF "concluded that it would be almost impossible for there to be effective collaboration between two systems if one was well funded and the other was not. While not always the case, DOD presently appears to have adequate funding to fulfill its health-care responsibilities. As this committee is well aware and our report details, the same is not true in the case of the Department of Veterans Affairs. As an economist, I feel that it is important to fashion good policy and then finance it adequately—hopefully in a manner that creates incentives for efficiency."

VA and the DOD will not be able to accomplish their mandated and/or recommended sharing goals until Congress addresses the mismatch between veterans' demand for services and the appropriated resources made available to the Veterans Health Administration of VA.

■ Leadership and Reporting

The VA-DOD Joint Executive Council should report, at least annually, to the House Committees on Armed Services and Veterans' Affairs on collaborative activities, including development of tools to measure outcomes relating to access, quality, cost, and progress toward meeting goals set for collaboration, sharing, and outcomes. Not only do the IBVSOs believe that there has been insufficient transparency in the work of various DOD and VA executive planning forums, but we also believe that without direct guidance from the respective Secretaries, to include responsibility and accountability of local management personnel, these sharing agreements are doomed to failure.

The CARES Commission report states that:

At those locations where collaboration was not successful or where it had been proposed for some

time but had not gained momentum, the Commission found...no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense to the local leadership in support of the collaboration.

From its review, the Commission concluded that to ensure a successful collaborative relationship between DOD and VA, there must be a clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The Commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

To this end, we believe that sharing agreements should be negotiated and written by local leadership, as they are now, but when ready for signature, they should be signed by the VA Under Secretary for Health and the appropriate service secretary. This would preclude future local management personnel from repudiating the agreements.

■ Joint Venture Sites

The DOD and VA have identified 74 sharing initiatives at the facility level, 35 of which appear promising to VA. The DOD has identified 20 and VA has identified 21 of these as priority initiatives. In addition, the DOD and VA announced, in October 2003, a series of demonstrations, required by P.L. 107-314, to test improving business collaboration between the DOD and VA health-care facilities. The Departments will use the demonstration projects at eight locations to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. *The Independent Budget* does not object to these ventures, but we do have serious concerns about their interaction with the VA CARES and DOD military transition facility (MTF) planning processes.

One issue regarding joint venture sites of real concern to the IBVSOs is physical access. Appendix A of the Secretary of Veterans Affairs CARES Decision,

released in May 2004, lists a number of existing or proposed joint venture sites located aboard military installations. In event of an increase in either terrorist threat level, or force protection level, the probability is that military installations will go into "lock down" status. This would effectively deny VHA enrolled patients, who are not military retirees, access to their health-care facility. We suggest that the involved military installations accept the VA Universal Identification Card for access to the installation and issue a vehicular decal to VHA patients. Currently the DOD issues color-coded vehicular decals to personnel requiring access to the facility. These decals are blue for military officers, red for enlisted personnel, green for civilian employees, and black for vendors and contractors. Perhaps a fifth color could be used for VHA patients.

■ VA and DOD Access Standards

VA has had access standards since 1995, but these standards have not been enforced. The DOD, however, has mandatory standards and is required, by statute, to meet them. The DOD standards drive funding levels to meet demand for care at MTFs and within TRICARE. In examining the funding mismatch, the PTF, in its report, concluded that the VHA should receive "full funding to meet demand, within access standards [...] PTF Report at 81."

■ Fully Fund Enrolled Veterans

The PTF recommended that he "Federal Government should provide full funding to ensure that enrolled veterans...are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism[.] PTF Report at 77.

The PTF recommendation is clear: The gap between resources and demand must be closed by increasing, *and sustaining*, VA health-care funding. As outlined elsewhere in *The Independent Budget*, we strongly recommend mandatory funding for all enrolled veterans whom the Secretary has directed care be provided to. The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration *cannot work without fundamentally addressing this issue*.

Recommendations:

Congress should provide the necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions to be made more expeditiously.

Congress should provide sufficient resources to enable the DOD and VA to enhance information management/information technology interoperability and efficiency.

Congress should mandate establishment of VA's published access standards in title 38 United States Code.

Congress should mandate that all interdepartmental agreements between departments of the executive branch be approved/signed off at the Under Secretary level or higher.

Congress should mandate that, in the case of joint health-care facilities operated by the DOD/VA, procedures be employed to preclude the loss of health care to veterans in case of an increased force protection condition.

Congress should require mandatory funding of VA health care.



Enrollment of Priority 4 Veterans Still Problematic

Many catastrophically disabled veterans are incorrectly classified as enrollment priorities 5, 6, 7, and 8.

Seven years ago Congress enacted Public Law 104-262, which specifies that veterans who are receiving an increased pension based on a need for regular aid and attendance or by reason of being permanently house-bound and other veterans who are catastrophically disabled will be classified as enrollment priority 4.

Prior to the Department of Veterans Affairs (VA) curtailing enrollment of priority group 8 veterans, all enrolled veterans that were entitled to be but were not classified as enrollment priority 4 have been denied VA health care. In the future it is possible that inadequate appropriations may force the Secretary to change enrollment policy with regard to priority 7 veterans. If that were to be the case, thousands of misclassified veterans could be affected.

The Veterans Health Administration (VHA) has not developed a consistent and effective mechanism for

identifying eligible veterans and properly classifying them as priority group 4. National service officers attempting to help veterans obtain appropriate reclassification to priority group 4 report that many times they are met with resistance and at times refusal from VA hospital staff.

There is no logical reason for the VHA to delay implementation of this law. Appropriate classification of eligible veterans to priority group 4 must be accomplished without further delay.

Recommendations:

The VHA should expedite the proper identification and classification of enrollment priority 4 veterans.

Congress should require the VHA to report on numbers of enrolled priority 4 veterans.



Emergency Services

Many enrolled veterans may be excluded from non-Department of Veterans Affairs (VA) emergency medical services.

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance. An eligible veteran who receives such care is not required to pay a fee to the private facility. However, eligibility criteria prohibit many veterans from receiving emergency treatment at private facilities.

To qualify under this provision, veterans not only must be enrolled in the VA health-care system, they also must have been seen by a VA health-care professional within the previous 24 months. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The Independent Budget veterans service organizations object to eligibility limitations on enrolled veterans.

We believe all enrolled veterans should be eligible for emergency medical services at any medical facility.

A related concern is the frequency with which VA denies payment for the emergency care to veterans, who as a result are charged by the private facilities. At times VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to, and emergency care at, a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., esophagitis, instead of the admitting diagnosis, e.g., chest pain. It is ludicrous to penalize a veteran for seeking emergency care when he or she is experiencing symptoms that manifest a life-threatening condition.

Recommendations:

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish and enforce a policy that it will pay for emergency care received by veterans at a non-VA

medical facility when they exhibit symptoms that a reasonable person would consider a manifestation of a medical emergency.

VA should establish a policy allowing all enrolled veterans to be eligible for emergency medical services at any medical facility.

**Prosthetics and Sensory Aids****Continuation of Centralized Prosthetics Funding:**

Problems in the distribution of Department of Veterans Affairs (VA) prosthetics and sensory aids continue to exist. Veterans continue to encounter obstacles in receiving timely and appropriate services and equipment. Program enhancements have been developed to eliminate or minimize these obstacles; however, they have not been fully implemented throughout the VA health-care system.

Continuation of the national centralized prosthetics budget has proven to benefit veterans significantly. The protection of these funds for prosthetics has had a major positive impact on disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetics needs of veterans with disabilities.

The IBVSOs also are in full support of the decision to distribute fiscal year 2005 (FY 2005) prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget reporting process.

Detractors of a centralized prosthetics budget continue to argue that when prosthetics funds are diminished, the facility or VISN is required to replenish the prosthetics account by utilizing the general operating funds. Many facility and fiscal managers who manage the general operating funds believe, because they are

responsible for the general operating funds, that they should also control the prosthetics funds. However, historical evidence has strongly proven that this practice results in funds being diverted from the prosthetics budget to other areas of the VHA facility. Conversely, the historical evidence also shows that centralization and protection of prosthetics dollars has resulted in improved services to disabled veterans.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetics funds through data entry and collection, validation, and assessment has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs continue to applaud senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2005. The allocated budget for prosthetics was approximately \$947 million, up from \$846 million in FY 2004. Funding allocations for FY 2005 were primarily based on FY 2004 NPPD expenditure data, coupled with Denver Distribution Center billings. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

While VHA facilities received a FY 2005 budget allocation of \$947 million, prosthetics requested approximately \$1.1 billion to cover the actual anticipated FY 2005 prosthetics budget. The advancements in prosthetics technology bring with them a high price. For example, a single prosthetic limb, the C-leg, has an anticipated cost of \$30,000; a single IBOT wheelchair, \$25,000; and a single service dog, \$20,000.

In FY 2006 the IBVSOs anticipate that the prosthetics budget will need to be increased to more than \$1.25 billion. Part of these funds must be used to allocate the latest technological advances in prosthetics and sensory aids. Considerable advances which are still being made in prosthetics technology, will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices.

The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are appropriately issued to veterans and that funding is available for such issuance.

Recommendations:

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including the latest advances in technology, so that funding shortfalls do not compromise other programs.

The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

The VHA should continue to utilize the PRUW to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the NPPD.

The VHA's senior leadership should continue to hold its field managers accountable for failing to ensure that data is properly entered into the NPPD.



Assessment and Development of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

Single-source national contracts for specific prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used as part of the PCMP process to award single-source national contracts for specific prosthetic devices. Mainly our concern lies with the high compliance rates that are contained in the national contracts. The typical compliance rate, or performance goals, in the national contracts awarded so far as a result of the PCMP has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off-contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from the VHA's standardization efforts because a "one size fits all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used

to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

The following is a synopsis of a statement made by a paralyzed veteran who is active on a PCMP workgroup:

We do not live in a one size fits all world, and when you spend 15-plus hours a day sitting down, the manner in which you do it is very personal and intimate. I would be a fool to think that, as a wheelchair user, I fully understand the factors that other wheelers need to consider in their selection of specific types or models of wheelchair. Disabled veterans who require a wheelchair for ambulating must be able to participate in the selection process and maintain their freedom of choice to help maximize their independence and facilitate their lifestyles. I understand that new users, or those with changing medical needs, require a lot of help in selecting the right chair from specialists. Experienced users have a better feel for their needs and limits and play a larger role or even a solo role in the selection process.

I cringe at the thought that someone may point to the work of this workgroup and say, "Sorry, but you can't have that wheelchair. A Department of Veterans Affairs (VA) workgroup has already decided what is best for you." I'm working hard to prevent a scenario like this from occurring. And I see from your thoughts that you understand my concerns, and I appreciate your efforts as a clinician and those of the other workgroup members, to address those concerns for the benefit of all disabled veterans who depend on these wonderful devices. Saving dollars at the expense of the disabled veteran would be a tragedy, not a victory.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA will routinely purchase threatens future advances. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market. Disabled veterans must have access to the latest devices and equipment, such as computerized artificial legs, stair climbing, and self-balancing wheelchairs and scooters, if they are to lead as full and productive lives as possible.

Another problem with the issuance of prosthetic items relates to surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stents, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are limiting the number of surgeries due to the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

Recommendations:

The VHA should continue the prosthetics clinical management program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are “off-contract” without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants due to cost considerations.



Restructuring of Prosthetics Programs:

Not all Veterans Integrated Service Networks (VISNs) have taken necessary action to ensure that their respective prosthetics programs have been restructured to provide timely and consistent service to the patients.

The Independent Budget veterans service organizations (IBVSOs) continue to support the Veterans Integrated Service Network (VISN) and its field efforts to ensure an acceptable consistent degree of medical services to meet the special needs of veterans. The IBVSOs believe Veterans Health Administration (VHA) headquarters must provide more specific information and direction to the VISNs on the restructuring of their prosthetics programs. The current organizational structure has communication inconsistencies that have resulted in the VHA central office trying to respond to various local interpretations of Department of Veterans Affairs (VA) policy. VHA headquarters must direct VISN directors to:

- Designate a qualified VISN prosthetics representative who will be the technical expert on all issues of interpretation of the prosthetics policies.
- Ensure that VISN prosthetics representatives have direct input into the performance evaluation of all prosthetics full-time employee equivalents at local facilities who are organized under the consolidated prosthetics program or product line.
- Ensure that VISN prosthetics representatives do not have collateral duties as a prosthetics representative for a local VA facility within his or her VISN.
- Hold each VISN prosthetics representative responsible for ensuring implementation and compliance with national prosthetics and sensory aids goals, objectives, policies, and guidelines
- Provide a single VISN budget for prosthetics and ensure that the VISN prosthetics representative has control of and responsibility for that budget.

Recommendation:

The VHA must require all VISNs to adopt consistent operational parameters and authorities for prosthetics policies. The individual VISN directors as well as the VHA central office should be held responsible for a consistent prosthetics program that reduces the need for central office interpretations.



Failure to Develop Future Prosthetics Managers:

There continues to be a serious shortage in the number of qualified prosthetics representatives who are available to fill current or future vacant positions.

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetics Representative Training Program. VHA's National Leadership Board has approved the reimplementation of this vital program. This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past there was a serious shortage in the number of qualified prosthetic representatives who were available to fill current or future vacant positions. This has led to many

inappropriate prosthetics personnel selections around the country. Currently seven prosthetics representative trainees from the 2003 program will graduate in 2005 and be ready for permanent placement. Twelve slots were approved for fiscal year 2004 (FY 2004) and another 12 are pending approval for FY 2005.

In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill

the critical VISN prosthetics representative positions. The IBVSOs believe the future strength and viability of VA's prosthetics programs depend on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients or the creation of prosthetics gatekeepers—individuals whose primary mission would be to save dollars at the expense of the veteran.

The prosthetics program must be improved. Continuing education and certification for field prosthetics staff is essential to this effort. The IBVSOs strongly encourage the VHA to continue to conduct quarterly VISN prosthetics representative training meetings. The prosthetics chief's national training conferences should also be continued. These conferences are held normally in conjunction with other rehabilitation services (e.g., blind rehabilitation, spinal cord injury, traumatic brain injuries, etc.).

In addition, appropriate prosthetics procurement personnel need to become certified as assistive technology suppliers, and orthotists/prosthetists need to be certified in their respective fields.

Recommendations:

The VHA must fully fund and implement its National Prosthetics Representative Training Program, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids, and continually allocate sufficient training funds and full time employee equivalents to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that their selected candidates for vacant VISN prosthetics representative positions possess the necessary competency to carry out the responsibilities of these positions.

The VHA and its VISN directors must ensure that prosthetics and sensory aids departments are staffed by appropriately qualified and trained personnel.



Consistent Application of National VHA Prosthetics Policies and Procedures:

Prosthetic services (e.g., the provision of hearing aids and eyeglasses, wheelchairs, artificial limbs, etc.) are still not provided uniformly across the nation to veterans who are enrolled and eligible for Department of Veterans Affairs (VA) care and treatment.

There continues to be a disparity in the application of a uniform national policy of distribution of prosthetics services across the nation. It is clear that senior leadership in the Veterans Health Administration (VHA) recognizes that this problem exists. Prosthetics and Sensory Aids continues to receive repeated requests to clarify instructions to its Veterans Integrated Service Network (VISN) prosthetics representatives concerning the "local" interpretation of policy in reference to the issuance of medically needed adaptive equipment (ingress/egress items). The policy for issuance of this equipment was clearly listed in VHA's prosthetics handbook (VHA Handbook 1173). In fact, the pros-

thetics handbook contains key language that addresses the problem of inconsistent application of prosthetic policies and provisions. The handbook indicates that the VHA is striving to provide a uniform level of services on a national level. Every section of the handbook specifically indicates that the policies contained therein are intended to set uniform and consistent national procedures for providing prosthetics and sensory aids and services to veteran beneficiaries. We believe national VHA officials need to review the training provided to the prosthetics representatives to ensure that national prosthetics policies are properly followed. Prosthetics leadership needs to ensure that VHA

Handbook 1173 is translated in VISN and facility-level operating guidelines accurately.

As noted above, policy enforcement and individual accountability is needed to effect positive change in local practices. In addition, the chief consultant for Prosthetics and Sensory Aids must work with all the VISNs to develop VISN-wide training initiatives that provide emphasis on ensuring that the interpretation of these national VHA policies and procedures on the issuance of prosthetic devices is consistent and appropriate, regardless of facility.

Recommendations:

The VHA must ensure that national prosthetics policies and procedures are followed uniformly at all VHA facilities.

All 21 VISN prosthetics representatives, in cooperation with the chief consultant for Prosthetics and Sensory Aids, need to develop, conduct, and/or continue appropriate prosthetics training programs for their VISN prosthetics personnel.

Mental Health Services

Department of Veterans Affairs (VA) leadership is to be applauded for adopting a framework for improving veterans' access to mental health services that foster rehabilitation and recovery.

Congress must provide the funding needed to sustain and expand those efforts

Our country's ongoing military engagement in Iraq and Afghanistan—and the debt we owe our returned and returning combatants—dramatically heightens the importance of ensuring that the VA health-care system is effectively treating veterans' psychic wounds as well as their physical injuries. Meeting this critical obligation will require VA to continue a rebuilding process aimed at transforming its mental health service delivery system. VA leaders have taken heroic first steps; Congress must lend needed funding support.

VA has long had a special obligation to veterans with mental illness, given both the prevalence of mental health and substance-use problems among veterans and the high numbers of those whose illness was of service origin. Recent VA data show that more than 480,000 veterans are service-connected for a mental disorder. Of that number, more than 215,000 are service-connected for post-traumatic stress disorder (PTSD). Some 17 percent—nearly 800,000—of the 4.7 million who received VA care in fiscal year 2003 received some type of mental health service.

The Independent Budget (IB) applauds Congress for having codified into law special safeguards to ensure that VA gives a priority to the needs of veterans with

mental illness. With the nation at war—and an already high percentage of returning veterans showing evidence of war-related mental health problems—VA's statutory obligation to veterans with mental health problems has special poignancy.

The VA health-care system has had an uneven record of service to veterans with mental health needs. Years of oversight repeatedly hammered at the enormous variability across the country in the availability of mental health treatment services and, where services were available, the relatively limited capacity devoted to rehabilitative help. But following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health services. Like other institutions providing mental health care, VA has tended to focus on managing the symptoms of patients' mental health problems. Yet the President's Commission found that many people with mental illness can regain a productive life, and it provided the President with a blueprint for system change based on the goal of recovery. VA leaders, to their credit, understood the importance of achieving the mental health system change the commission envisioned and developed an agenda

(built in significant part on earlier recommendations of VA's Committee on the Care of Severely Mentally Ill Veterans) for realizing that goal. Under VA Secretary Anthony J. Principi's committed leadership, the transformation under way in VA mental health service delivery—built on an understanding that veterans with mental disorders can recover and lead productive lives—is vitally important to keeping faith with the obligations VA has to America's veterans.

The Secretary's establishment of a task force in December 2003 to review VA's ability to provide mental health and substance abuse treatment and to provide needed recommendations marks an important step on the road to transforming VA mental health care. To his great credit, the Secretary has adopted the recommendations advanced by that task force, including measures aimed at eliminating the variability and gaps in VA care for veterans with mental illness, restoring VA's ability to deliver state-of-the-art care to veterans with substance abuse disorders, establishing case management programs for homeless veterans with mental health problems, and providing supportive rehabilitative services to veterans with mental illness.

Any transformation or major change—from eliminating the longstanding variability in VA care to changing its mission from symptom-management to recovery—will take sustained leadership and support on the part of VA and Congress. Given the wide gap between VA's mental health capacity and the needs veterans have for mental health treatment and support services, these changes will also require new funding.

While VA leaders have made important initial steps to move VA toward state-of-the-art care for veterans with mental health problems, we must acknowledge, and set a course to meet, the many serious needs the system still faces. Among the gaps yet to be bridged:

- VA does not have in place the needed arsenal of rehabilitative services—from supported employment to housing assistance to peer supports—that veterans need to achieve the fullest possible recovery from chronic mental illness.
- VA and the DOD have not yet developed needed mechanisms to provide screening and early intervention services to help returning service members get early treatment for war-related mental health problems.

- Veterans with substance use problems, and those with co-occurring mental health and substance-use problems, still do not have adequate access to VA treatment.
- VA lacks the capacity to meet the needs of veterans with special needs, including aging veterans with profound mental illness and/or dementia-related conditions, and female veterans who have mental health needs associated with sexual assault in service.

In what should be a shared journey, VA and Congress each must do its part to make VA mental health care a real priority and ensure that priority is maintained. Both must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness becomes a guiding beacon for VA mental health planning and programming.

The Independent Budget recognizes that bridging the gaps still facing VA mental health care must be approached with thoughtful deliberation and care and recommends that funding be augmented steadily over a five-year period.

Recommendations:

Congress must incrementally augment funding for specialized treatment and support services for veterans who have mental illness, PTSD, or substance-use disorders by \$500 million each year from fiscal year 2006 (FY 2006) through FY 2010.

VA must adopt a strategic plan for mental health services and give priority to realizing the elements of such a plan.

The Veterans Health Administration (VHA) must invest resources in programs to develop a continuum of care that includes intensive case management, psychosocial rehabilitation, peer support, integrated treatment of mental illness and substance-use disorder, housing alternatives, work therapy and supported employment, and other necessary support services.

VA must press the Administration and the DOD to ensure the development of a seamless initiative to

provide early intervention services to help returning service members get early treatment for war-related mental health problems.

The VHA, its networks, and its facilities, should partner with mental health advocacy organizations, such as

the National Mental Health Association, and veterans service organizations, to provide support services, such as outreach, educational programs, peer—and family—support services, and self-help resources.



Specialized Services Issues

Blinded Veterans

The Veterans Health Administration (VHA) needs to provide a full continuum of vision rehabilitation services.

The VA Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded and severely visually impaired veterans. VA currently operates 10 comprehensive residential blind rehabilitation centers (BRCs) across the country. Historically, the residential BRC program has been the only option for severely visually impaired and blinded veterans to receive services.

As the VHA made the transition to a managed primary care system of health-care delivery, the BRS failed to make the same transition for rehabilitation services for blinded veterans. *The Independent Budget* believes it is imperative that the VA BRS expand its capacity to provide blind rehabilitation services on an outpatient basis when appropriate. More than 1,600 blinded veterans are awaiting entrance into 1 of the 10 VA BRCs. Then, in order to gain access to one of these programs, the veteran must wait an average of 24 weeks. Many of these blinded veterans do not require a residential program. If a veteran cannot or will not attend a residential BRC, he or she does not receive any type of rehabilitation.

The Independent Budget encourages funding for additional research into alternative models of service delivery to identify more cost-efficient methods of providing essential blind rehabilitation services. Alternative methods of delivering rehabilitative services must be identified, tested, refined, and validated

before the existing comprehensive residential BRC programs are dismantled. Innovative programs like the outpatient nine-day rehabilitation program, called Visual Impairment Services Outpatient Rehabilitation Program (VISOR), at the Department of Veterans Affairs Medical Center (VAMC), Lebanon, Pennsylvania, must be encouraged and replicated. VISOR offers skills training, orientation and mobility, and low-vision therapy. This new approach combines the features of a residential program with those of outpatient service delivery.

Congressionally mandated capacity must be maintained. The BRS continues to suffer losses in critical full-time employees, compromising its capacity to provide comprehensive residential blind rehabilitation services. Many of the blind rehabilitation centers are unable to operate all of their beds because of the reduction in staffing levels. Other critical BRS positions, such as full-time Visual Impairment Services Team (VIST) coordinators and blind rehabilitation outpatient specialists (BROS), have been frozen, postponed indefinitely, or eliminated. Currently, there are only 23 BROS positions. In addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, BROS provide blind rehabilitation training in veterans' homes. This service is particularly important for blinded veterans who cannot be admitted to a residential blind rehabilitation center.

Recommendations:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the enactment of P.L. 104-262.

The VHA must rededicate itself to the excellence of programs for blinded veterans.

The VHA must require the Veterans Integrated Service Networks (VISNs) to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

The VA must require the VISNs to include in their five-year strategic plans the provision of a full continuum of vision rehabilitation care.

The VHA headquarters must undertake aggressive oversight to ensure appropriate staffing levels for blind rehabilitation specialists.

The VHA must increase the number of blind rehabilitation outpatient specialist positions.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff. When disputes over such selections cannot be resolved between the BRS director and local management, they must be elevated to the Under Secretary for Health for resolution.

BRS national program consultants, currently decentralized, must be recentralized and report directly to the BRS director in the Department of Veterans Affairs Central Office.

VA must seek legislative relief to amend the beneficiary travel program to include those severely disabled veterans accepted to one of the special-disabilities programs who are currently eligible to receive this benefit.

**Spinal Cord Dysfunction**

The recruitment of qualified staff to support the mission of the spinal cord injury/dysfunction (SCI/D) program remains the major impediment to providing quality care to the patient with spinal cord injury or dysfunction.

The Department of Veterans Affairs (VA) is currently experiencing a serious shortage of qualified, board certified SCI chiefs of service. Several major SCI programs are under "acting" management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged; in one instance, an SCI service had an extended search committee in place for more than two years, and another has been without a full-time chief for more than three years.

It must be recognized that SCI medicine is a major subspecialty, and clinical leadership of these departments is as vital to the VA's health-care program as the specialties of general medicine and surgery. Neglect to

promptly fill these vacancies reflects adversely on the management of the local VA hospital and the Veterans Health Administration (VHA) systemwide. It can be assumed that either the process is flawed, applicants were not available, or that appropriate incentives have not been included to make these positions attractive.

■ Nursing staff:

The Independent Budget veterans service organizations continue to support the belief that base salaries for nurses who provide bedside care is still too low to be competitive with community hospital nurses, resulting in a high turnover as these individuals leave VA for more attractive compensations.

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient in the middle of the scoring system is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. These hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers bedside nursing care hours over a week, month, quarter, or the year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on bedside nursing care. It does not include administrative nurses, non-bedside specialty nurses or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the SCI/D patient.

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2004-004. This staffing ratio was derived from 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2004-044 mandates 1,347.4 bedside nurses provide nursing care for 85 percent of the available beds at the 23 SCI centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of fiscal year 2004, nurse staffing was 1,315.3. This number is 32.1 FTEEs short of the mandated requirement of 1,347.6. The 1,315.3 FTEEs include nursing administrators and non-bedside RNs (75.24) as well as light duty staff (42.5). Removing the administrators and light duty staff makes the total number of nursing personnel 1,197.56 to provide bedside nursing care.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 489.5 RNs working in spinal cord injury. Of that number, 75.24 are in non-bedside or administrative positions, leaving 414.26 RNs providing bedside nursing care. With 1,315.3 nursing personnel and 414.26 of those RNs, this leaves an RN ratio of 31.49 percent to provide bedside nursing care. Even if the non-bedside RNs were included, the percentage of RNs is 37 percent. These numbers are far below the mandated 50 percent RN ratio.

SCI facilities recruit only to the minimum nurse staffing required by VHA Directive 2004-044. As shown above, when the minimal staffing levels include non-bedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of staffing.

The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. The Agency for Healthcare Research and Quality (AHRQ) published information showing that low RN staffing caused an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI service is crucial in promoting optimal outcomes.

This nurse shortage has manifested itself recently by VA facilities beginning to admit non-SCI patients to the SCI center wards. One acute care VA facility, until advised by VHA central office, was admitting patients ranging from mental health to general medicine in SCI designated beds. That VA facility was faced with a severe nursing shortage throughout the medical center and unable to open beds to accommodate these patients. Situations such as this create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

Recruitment and retention bonuses have been effective at several VA SCI centers, resulting in an improvement in both quality of care for veterans and the morale of the nursing staff. However, the facilities face a dilemma when considering to offer recruitment or retention bonuses. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

Recommendations:

The VHA should authorize substantial recruitment incentives and bonuses to attract board certified physicians for the positions of SCI chief.

The VHA should establish a policy that would improve the recruitment process for chiefs of SCI and eliminate long delays in filling these positions.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.



Gulf War Veterans

Gulf War veterans still suffer from undiagnosed illnesses related to their service.

Controversy over "Gulf War Syndrome" still exists more than a decade after the start of the Gulf War. Sick Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain. Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf Theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf War veterans suffer from real illnesses, there is no single disease or medical condition affecting them.

In the 13 years since the Gulf War, both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) have seen many service members and veterans with concerns regarding undiagnosed illnesses and Gulf War Syndrome. Although some headway has been made in diagnosis, treatment, and payment of disability compensation, further research by both departments is needed. Moreover, we are now confronted by an additional issue. The international

war on terrorism has put our troops on the ground in Iraq and Afghanistan. Many of these young men and women have fought, are fighting, and are living in the same areas as did our Gulf War veterans. *The Independent Budget* veterans service organizations (IBVSOs), therefore, expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses the veterans of the Gulf War have experienced.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled due to their military service in the Gulf War. Unfortunately, veterans returning from all of our nation's wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service-connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. P.L. 105-277 requires that VA and the National Academy of Sciences (NAS) determine to which hazardous toxins members of the armed forces may have been exposed while serving in the Persian Gulf. Upon iden-

tification of those toxins, the NAS will identify the illnesses likely to result from such exposure, for which a presumption of service connection is or will be authorized. Accordingly, the IBVSOs urge that Congress extend the provision of P.L. 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Gulf Wars. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine "incubation times" in which conditions associated with Gulf War service will manifest.

Many Gulf War veterans are frustrated over VA medical treatment and denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. In this connection, VA uses clinical practice guidelines for chronic pain and fatigue. VA has not yet, however, developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle these cases in a traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines, as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA's ability to provide appropriate and adequate compensation.

On a more positive note, recently enacted legislation includes poorly defined illnesses, such as fibromyalgia and chronic fatigue syndrome, under the "undiagnosed illness" provision. Previously, many Gulf War veterans received diagnoses of these conditions, yet were denied compensation simply because they were diagnosed. Because of passage of P.L. 107-103, which

became effective March 1, 2002, Gulf War veterans diagnosed with chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome now qualify for VA compensation for those conditions. Additionally, the Secretary of Veterans Affairs has granted presumption for service connection to those Gulf War veterans diagnosed with ALS (Lou Gehrig's Disease). The Secretary should reexamine VA regulations for disabilities due to undiagnosed illnesses, with a focus on the intent of Congress in P.L. 106-446 to ensure Gulf War veterans are fairly and properly compensated for their disabilities.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War-related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support vigorously significant increases in the effort and funds devoted to such research by both federal government and private entities.

A new program announced November 12, 2004, by the Secretary of Veterans Affairs calls for up to \$15 million for additional research funding for Gulf War illnesses. This new program reflects a new level of cooperation and initiatives specifically dedicated to Gulf War illnesses.

Recommendations:

VA should continue to foster and maintain a close working relationship with the NAS in an effort to determine which toxins Gulf War veterans were exposed to and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and the NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.



Women Veterans:

The Department of Veterans Affairs (VA) must be prepared to meet the needs of increasing numbers of women veterans seeking health-care services and ensure that its special disability programs are tailored to meet the unique health concerns of our newest generation of women veterans, especially those who have served in combat theaters.

In contrast to the overall declining veteran population, the female veterans' population of the United States is increasing. According to a 2003 United States Census Bureau survey, of the 23.7 million veterans, 1.4 million, or 6 percent, were women. Likewise, the percentage of active duty personnel who are women has increased significantly from 1.6 percent in 1973 to 15 percent at the start of 2003. Today, more than 213,000 women serve on active duty in the military services of the Department of Defense. Another 3,800 women serve in the active Coast Guard. The Reserve and National Guard components also have an increasing percentage of women, who constitute 17.2 percent of the current personnel with 151,441. As of July 28, 2004, 20,255 women veterans served and have separated from military service in Operation Iraqi Freedom (OIF) and Enduring Freedom (OEF) theaters of operations.

As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services. According to VA, among the more than 20,000 women having served in OIF and/or OEF, 20 percent, or 4,045, have received health care from VA since separation from military service. Women veterans comprise approximately 5 percent of all users of VA health-care services and within the next decade this figure is expected to double. Additionally, the average woman veteran is younger than her male counterpart and more likely to belong to a minority group. The Bureau of Labor and Statistics reported in 2003 that 46.3 percent of women veterans are less than 45 years of age. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is responsive to the unique demographics of this veterans' population and adjust programs and services as needed to meet their changing health care needs. As we see growth in the number of women veterans using VA health-care services, we also expect to see increased VA health-care expenditures for women's health programs.

VA is obligated to deliver health-care services to women veterans equal to those provided to male veterans. The VA Veterans Health Administration (VHA) Handbook 1330.1, "VHA Services for Women Veterans," states:

It is a VHA mandate that each facility, independent clinic and Community-Based Outpatient Clinic (CBOC) ensure that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions that is equal in quality to that provided to male veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that although VA has markedly improved the way health care is being provided to women veterans, privacy and other deficiencies still exist at some facilities. VA needs to enforce, at the Veterans Integrated Service Networks (VISNs) and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities. The VHA has an excellent handbook for providing services for women veterans. Unfortunately, these guidelines and directives are not always followed at the VISNs or local levels.

According to VHA Handbook 1330.1, "VHA Services for Women Veterans":

Clinicians caring for women veterans in any setting must be knowledgeable about women's health care needs and treatments, participate in ongoing education about the care of women, and be competent to provide gender-specific care to women. Skills in screening for history of sexual trauma and working with women who have experienced sexual trauma are essential.

The model used for delivery of primary health care to women veterans using VA health-care services is vari-

able. There has been a trend in the VHA away from comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. Most facilities provide care to women in integrated primary care settings and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based care delivery model to an outpatient health-care delivery model focused on preventative medicine. The IBVSOs are seriously concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report, "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services," stated, in part:

VA women's clinics were established because, unlike the private sector, where women make up 50 to 60 percent of a primary care practitioner's clientele, women veterans comprise less than 5 percent of VA's total population. As a result, VA clinicians are generally less familiar with women's health issues, less skilled in routine gender specific care, and often hesitant to perform exams essential to assessing a woman's complete health status. With the advent of primary care in VA, many women's clinics are being dismantled and women veterans are assigned to the remaining primary care teams on a rotating basis. This practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. In cases where there are relatively low numbers of women being treated at a given facility, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health. Likewise, we agree that the health-care environment directly affects the quality of care provided to women veterans and significantly impacts the patient's comfort and feeling of safety and sense of welcome.

We are pleased that VA, in recognition of the changing demographics in the veteran population and the special health-care needs of women veterans, has established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004 VHA's Office of Research and Development held a groundbreaking conference titled "Moving Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying the research priorities and infrastructure required to fill these gaps. The acting chief of VA's Research and Development department noted that VA is working to develop a strategic plan for women's health research. We strongly encourage VA to evaluate its clinical guidelines, best practice models, and performance and quality improvement measures to determine which health-care delivery model demonstrates the best clinical outcomes for women veterans.

The IBVSOs are also concerned about the availability of quality mental health services for women veterans, especially women veterans who have mental health needs associated with sexual trauma during military service. The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, and we agree, that it is "essential that VA staff recognize the importance of the environment in which care is delivered to women veterans, and that VA clinicians possess the knowledge, skill, and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

According to VA, approximately 20 percent of the women screened between fiscal years 2002 and 2004 responded "yes" to experiencing military sexual trauma (MST) compared to 1 percent of men screened. In response to these reports, VA has committed to establishing a committee to explore ways to address the mental health needs of women veterans and to improving mental health services to women who have experi-

enced MST. We encourage the VHA to implement recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including screening all women for MST, development of an MST provider certification program, providing separate subunits for inpatient psychiatry and other residential services, improved coordination with the Department of Defense (DOD) on transition of women veterans, and promotion and advancement of women's health research agenda. We also encourage VA to strengthen its partnership with the DOD, to ensure a seamless transition for women from military service to veteran status. Improvements in sharing data and health information between the departments is essential to understanding and best addressing the health concerns of women veterans.

We are pleased VA is preparing for the return of women veterans from combat theaters and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OIF/OEF women veterans in anticipation of gender-specific health issues, including recommendations for women veteran program managers to develop educational literature targeting women veterans and listing VA contacts in local catchment areas.

Women veterans program managers (WVPMs) are another key component to addressing the specialized health-care needs of women veterans. These program directors are instrumental to the development, management, and coordination of women's health services at all VA facilities.

According to VHA Handbook 1330.1, "VHA Services For Women Veterans":

Each VHA facility must have an appointed WVPM. [The WVPM appointed by the medical center Director should be] a health care professional...who provides health care services to women as a part of their regular responsibilities. The WVPM will be a member of the Women Veterans Primary Health Care Team [and must participate] in the regular review of the physical environment, to include the review of all plans for construction, for the identification of potential privacy deficiencies, as well as availability and accessibility of appropriate equipment for the medical care of women.

Given the importance of this position, the IBVSOs are concerned about the actual amount of time WVPMs are able to dedicate to women veterans issues. VA staff members assigned to these positions frequently complain that their duties as coordinators are collateral or "secondary" to their overall responsibilities and that they generally do not have sufficient time to devote to women veterans' issues. WVPMs must have adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to women veterans is necessary because women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often smaller programs, such as women veterans' programs, are endangered. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to ensure priority is given to women veterans' programs so that quality health care and specialized services are equally available to women veterans as male veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers, such as exists between women and men in VA facilities. Given the changing roles of women in the military, VA must also be prepared to meet the specialized needs of women veterans who were sexually assaulted in military service or catastrophically wounded in combat theaters suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must prepare for health issues that pose special problems for women. Finally, the IBVSOs recommend VA focus its women's health research on finding which health-care delivery model demonstrates the best clinical outcomes for women veterans. Likewise, VA should create a strategic plan to collaborate with the DOD to collect critical information about the health and health-care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for women's health research agenda.

Recommendations:

VA must ensure laws, regulations, and policies pertaining to women veterans' health care are enforced at VISN and local levels.

VA must ensure that priority is given to women veterans' programs and evaluate which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans, as women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women's health,

participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPs are authorized sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs for post traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to women veterans as male veterans.

VA should collaborate with the DOD to collect critical information about health and health needs of women veterans to best identify strategic priorities for women's health research agenda.

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Long-Term Care Issues

The Department of Veterans Affairs (VA) is ill-prepared to meet the long-term care needs of America's aging veteran population.

VA will see a significant increase in long-term care needs over the next decade. The number of aging veterans is increasing rapidly, and those who are 85 years old and older are expected to increase from approximately 870,000 to 1.3 million over this period. This group of veterans will have a significant need for institutional care and require a variety of noninstitutional long-term care services.

Concern over VA's ability to meet the growing veteran demand for long-term care services was highlighted during testimony by the Government Accountability Office (GAO) on January 28, 2004, before the House Committee on Veterans' Affairs. The GAO stated that:

"Recent trends in VA nursing home care and noninstitutional service delivery raise important questions, particularly whether access to services is sufficient to meet the needs of a rapidly growing elderly veteran population."

This concern is further magnified by VA's fiscal year 2005 (FY 2005) budget submission workload numbers that propose a decrease in capacity for the core of VA's institutional long-term care programs. The subacute program will experience a modest increase. The State Home Domiciliary and the Community Nursing Home Programs, while not decreasing, are expected to remain at FY 2004 levels.

VA Institutional Long-Term Care Workload

(The following data is taken from VA's FY 2005 budget submission and is expressed in average daily census (ADC) numbers):

	2003	2004	2005	INCREASE/(DECREASE)
VA Residential Rehab.	5,425	5,378	5,312	(66)
Psych. Res. Rehab	1,436	1,279	1,143	(136)
State Home Domiciliary	3,758	4,389	4,389	0
Subacute	595	613	686	73
VA Nursing	12,339	11,000	8,500	(2,500)
Community Nursing	4,069	4,069	4,069	0
State Nursing	17,000	18,000	19,010	(1,010)
Institutional Total	44,622	44,728	43,109	(1,619)

■ Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, the Secretary of the Department of Veterans Affairs (VA), Anthony J. Principi, forwarded its report to Congress concerning the results of VA's pilot program to provide assisted living services to veterans. The pilot program was authorized by the "Veterans Millennium Health Care and Benefits Act," P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VA's Veterans Integrated Service Network (VISN) 20. VISN-20 includes the states of Alaska, Washington, Oregon, and the western part of Idaho.

The VA ALPP was implemented in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Roseburg, and White City, Oregon; Spokane, Washington; and Puget Sound, Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

VA's report on the overall assessment of the ALPP stated: "The ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."

Some of the main findings of the ALPP report include the following:

- ALPP veterans showed very little change in health status over the 12 months post-enrollment. As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that ALPP may have helped maintain veterans' health over time.
- The mean cost per day for the first 515 veterans discharged from the AALP was \$74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.
- The mean cost to VA for the veterans' stay in an ALPP facility was \$5,030 per veteran. The additional cost of case management during this time was \$3,793 per ALPP veteran.
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.

- The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment: 22 percent received assistance with between 4 and 6 ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with between 1 to 3 ADLs; while 35 percent received no assistance.
- Case managers helped ALPP veterans apply for VA aid and attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.
- Veterans were very satisfied with ALPP care. The highest overall scores were given to VA case managers (mean = 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82)
- Vendors are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).
- Case managers were very satisfied with ALPP. Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks."

While assisted living is not currently a benefit that is available to veterans, even though some veterans have eligibility for nursing home care, the IBVSOs believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care. *The Independent Budget* recommends that Congress expand VA's Assisted Living Pilot Program across the entire country, to every VA health-care network.

Secretary Principi's cover letter conveying the ALPP report to Congress stated that VA is not seeking authority to provide assisted-living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is just one of the serv-

ices that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

■ Capital Asset Realignment for Enhanced Services (CARES) and Assisted Living

Secretary Principi's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources.

The IBVSOs concur with these recommendations and the application of VA's enhanced-use lease program in this area. However, we believe that any type of VA enhanced-use lease agreement for assisted living must be accompanied with the understanding that veterans have first priority for care.

■ Summary

The VA ALPP report seems most favorable and appears to be an unqualified success. However, the IBVSOs believe that to gain a further understanding of how the ALPP program can benefit all veterans, it should be replicated across the entire country.

Regarding CARES, the IBVSOs believe that VA enhanced-use lease agreements can be a useful tool in attracting the assisted living industry to consider vacant and underutilized VA property for their future site needs.

Recommendations:

Congress should authorize VA to expand its Assisted Living Pilot Program to include an initiative in each VA Veterans Integrated Service Network. This expanded effort will allow VA to gather important regional program cost and quality information.

Congress should call upon VA to conduct a cost-and quality-comparison study that compares the ALPP experience to cost and quality information it has

compiled for VA nursing home care, community contract nursing home care, and state veterans' nursing home care. When completed, this long-term care program cost-comparison study should be made available to Congress and veterans service organizations.

Congress should consider adding assisted living as a covered benefit that would be an alternative to VA provided or paid nursing home care.

Regarding CARES, VA should cultivate the assisted living industry as a possible market for vacant and underutilized VA space. However, VA should insist that veterans be given a resident preference whenever an assisted living enhanced-use lease proposal becomes a reality.



VA Institutional (Nursing Home Care) Issues

Operation Issues: Capacity Mandate

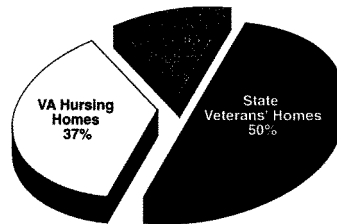
Once again, VA has failed to meet the congressional average daily census (ADC) requirement of 13,391 for VA nursing home care as mandated by P.L. 106-117, "The Veterans Millennium Health Care and Benefits Act of 1999" (Mill Bill). VA's budget submission for fiscal year 2005 (FY 2005) projected the ADC goal for VA nursing home care to be at 8,500 (Note: VA's unofficial ADC VA nursing home care estimate for the end of FY 2004 is said to be approximately 12,400).

It appears that VA does not believe it must follow the congressional Mill Bill mandate. VA is clearly moving to reduce its own nursing home capacity and expenditures by shifting its nursing home responsibility to state veterans' homes. State veterans' homes are an attractive option for VA because VA pays about one-third of the cost of care in state veterans' nursing homes. The Government Accountability Office (GAO) reported the following examples: First, the percentage of workload in VA's own nursing homes declined from 40 to 37 percent between 1998 and 2003. Thirteen Veterans Integrated Service Networks (VISNs) provided a smaller percentage of workload in VA-operated nursing homes during this period. Second, the percentage of VA nursing home workload met in state veterans' homes increased from 43 to 50 percent between 1998 and 2003. Third, the percentage of workload in community nursing homes declined from 17 to 13 percent. Seventeen VISNs reduced the percentage of their nursing home work-

load in community nursing homes during this period. (Note: The GAO reported in November of 2004 (GAO report-05-65) that in FY 2003 half (50 percent) of VA's average daily nursing home workload was provided in state veterans' nursing homes, 13 percent was provided in community nursing homes, and 37 percent was provided in VA nursing homes.)

The following pie chart depicts the percentages of VA's nursing home workload for 2003 (from GAO Report to the Chairman, Committee on Veterans' Affairs, House of Representatives, VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps (GAO-05-65) (2004):

CHART 2.
2003 VA NURSING HOME WORKLOAD



Meanwhile, VA is trying to persuade Congress to modify the capacity mandate of the Mill Bill requiring an ADC 13,391 (1998 baseline year) for only VA nursing home care to include an ADC number that includes a combination of VA nursing home, community nursing home, and state veterans' nursing home care. This new methodology would allow VA to dramatically reduce its VA nursing home capacity and backfill with contract community nursing home beds or state veterans' home bed space if available.

The Independent Budget veterans service organizations are opposed to this proposal because it shifts VA's responsibility to veterans and reduces its internal capacity to care for America's aging veterans. Care for aging veterans should not be shifted to private providers because it is more convenient or more cost-effective to do so. VA nursing home care is an entitlement to certain eligible veterans, and these individuals should not be forced to accept other forms of nursing home care because VA has reduced its capacity.

Advantages of VA nursing home care include prompt access to VA medical care because VA nursing homes are either co-located or in close proximity to, VA medical centers. In these situations, prompt access to medical treatment for elderly veterans is easily facilitated and continuity of care can be readily achieved. Also, veteran patients with complex specialized medical conditions and high acuity needs are not easily placed in community nursing homes or state veterans homes. In many instances, these veterans can only be placed in VA nursing home facilities. VA nursing homes provide a rich veteran culture for veteran patients that cannot be matched by community nursing homes. Patient surveys indicate that VA nursing home quality is superior to private community nursing homes, and these VA facilities instill a patriotic spirit of responsibility in its workforce. Accountability for care in VA facilities is not clouded by layers of community nursing home management or reduced by remote off-site locations. Regarding state veterans' homes, admission can sometimes be a barrier because admission is determined by eligibility criteria established by the states. The VA may refer patients to these state veterans' nursing homes for care, but it does not control the admission process, and therefore cannot guarantee admission.

■ Operational Issues: Data Collection

VA's lack of data on veterans who have been shifted from VA nursing home care to state veterans' homes and to community nursing homes is a serious issue. The November 2004 GAO report cited earlier (GAO-05-65) pointed out that gaps in VA data on length of stay and eligibility for state veterans' homes and community nursing homes impedes VA's ability to provide adequate program oversight.

The GAO recommended that VA collect data on veterans' length of stay and eligibility for community nursing homes and state veterans' nursing homes comparable to data VA collects for VA nursing homes. While VA stated it concurred in principle with GAO's recommendations, it did not indicate specific plans to collect the data GAO recommended.

■ Institutional Care Budget Issues: Dollars and Venues of Care

The November 2004 GAO report cited earlier (GAO-05-65) also reported that "the VA currently operates a \$2.3 billion nursing home program that provides or pays for veterans' care in VA's 21 health-care networks. Meeting veterans' nursing home care needs is a key issue for VA because it has a large elderly population, many of whom are in need of such care."

In fiscal year 2003, VA nursing homes accounted for almost \$1.7 billion, or about three-quarters of the approximately \$2.3 billion VA spent to provide or pay for veterans to receive nursing home care. Care in state veterans' nursing homes accounted for about \$352 million, and care in community nursing homes accounted for about \$272 million.

In 2003, VA operated nursing homes in 132 locations, which are located throughout VA's 21 health-care networks. Almost all of these locations are attached or in close proximity to a VA medical center. Also in 2003, VA contracted with 1,723 community nursing homes through its medical centers and with an additional 508 more nursing homes under its Regional Community Nursing Home initiative. Finally, 109 state veterans' nursing homes located in 44 states and Puerto Rico received VA payments to provide care in 2003.

VA Institutional Care Budget Obligation History and FY 2005 Forecast

The following data was taken from VA's FY 2005 budget submission:

OBLIGATIONS (\$000):	2003	2004	2005	INCREASE/DECREASE
Nursing Home Care	\$2,412,858	\$2,523,494	\$2,029,442	(\$494,051)
Subacute Care	\$293,042	\$263,738	\$237,364	(\$26,374)
Residential Care	\$477,384	\$525,998	\$578,176	\$52,178
GEM 1/	\$4,667	\$4,821	\$4,980	\$159
GRECC	\$31,682	\$32,728	\$33,808	\$1,080
Total Institutional	\$3,219,633	\$3,350,778	\$2,833,770	(\$467,008)

VA's budget submission for FY 2005 proposed to reduce VA expenditures for institutional nursing home care by \$494 million from the FY 2004 level. This comes at a time when GAO says VA is expecting a greater demand for these services over the next decade.

Congress must appropriate sufficient operational dollars for VA to reach the VA nursing home capacity mandate of the Mill Bill. Additionally, Congress must provide the funding necessary to meet the future demand for both institutional and noninstitutional long-term care that is expected over the next decade.

■ VA Noninstitutional (Home- and Community-Based) Care Issues

Noninstitutional long-term care programs have developed from the philosophy that home- and community-based services are the preferred settings for aging veterans. This is certainly true; most aging veterans wish to remain in their own homes as long as possible. However, there is also an economic factor driving the expansion in home- and community-based long-term care service delivery. Simply put, home- and community-based care are less expensive than institutional nursing home care services.

"The Veterans Health Care Eligibility Reform Act of 1996" (P.L. 104-262) provided for a uniform benefits package for enrolled veterans, including home health care and hospice care. The Mill Bill of 1999 directed that VA shall provide access to a continuum of extended care services including alternatives to institutional long-term care.

In recent years, VA has been increasing its level of home- and community-based long-term care services, but more needs to be done and program gaps still exist. GAO issued a report in May of 2003 (GAO-03-487) titled "Service Gaps and Facility Restrictions Limit Veterans' Access to Non-Institutional Care." The report stated that of the 139 VA facilities reviewed, 126 do not offer all six of the noninstitutional services mandated by the Mill Bill. The authors of *The Independent Budget* believe many of these problems still exist and that the GAO should be asked to review the current status of access to these services.

VA Noninstitutional Long-Term Care Workload

The following data is taken from VA's FY 2005 budget submission and is expressed in average daily census numbers:

HOME & COMM. CARE	2003	2004	2005	INCREASE/DECREASE
Home Based Primary Care	8,368	10,471	14,592	4,121
Purchased Skill. Home Health Care	4,336	5,424	6,400	976
VA/Contract Adult Day Care	1,263	1,528	1,803	275
Homemaker Home Health	4,317	5,400	6,372	972
Comm. Residential Care	6,050	6,050	6,050	0
Home Respite	2	318	636	318
Home Hospice	77	440	671	231
H & C-B Total	24,413	29,631	36,524	6,893

Operational Issues: Program Service Gaps

As previously mentioned, the May 2003 GAO report (GAO-03-487) identified a number of operational problems with VA's noninstitutional long-term care programs. Among these, GAO cited service gaps and facility restrictions that limit access to these services. The service gaps identified by GAO included VA's services for adult day care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. The GAO also reported that access is even more limited than the numbers suggest because even when VA facilities offer these services, they often do so in only part of the geographic area they serve.

Operational Issues: Data Collection

In order to eliminate service gaps in noninstitutional care services, VA must mount an intensive data collection effort concerning the availability of access to noninstitutional services across the entire VA system. Each VA network and each individual facility must be surveyed to determine that all of VA's noninstitutional care services are operational and readily accessible. Data on program availability and workload will help VA understand current utilization and predict future need.

Noninstitutional Care Budget Issues: Dollars and Venues of Care

VA's budget submission for FY 2005 called for an increase in VA expenditures for noninstitutional care by \$132 million, for a total of \$514.9 million. The 2004 level of VA spending on noninstitutional care for FY 2004 level was \$382.9 million. While increased VA spending on noninstitutional long-term care services seems like a step in the right direction, it must be understood that VA simultaneously proposed reducing the institutional care budget by \$467 million.

While it may be true that noninstitutional care services may reduce the number of veterans who require institutional care (nursing home) services in the short run, *The Independent Budget* authors are concerned that the demand for both programs is constantly rising because of an aging veteran population.

VA can no longer continue the shell-game of shifting resources from institutional nursing home care services by ignoring the Mill Bill's capacity mandate to meet the growing demand for noninstitutional care. Congress must appropriate more dollars to meet veteran demand for both institutional and noninstitutional long-term care services. VA is serving record numbers of new veterans each year. Shifting resources from one program to another does not solve the increasing demand problem of an aging veteran population; it serves only to stress existing programs that veterans desperately need.

VA Noninstitutional Care Budget Obligation History and FY 2005 Forecast

The following data was taken from VA's FY 2005 budget submission:

OBLIGATIONS (\$000):	2003	2004	2005	INCREASE/DECREASE
Home-Based Primary Care	\$72,688	\$78,350	\$113,339	\$34,989
Contract Home Health Care	\$105,911	\$140,286	\$171,813	\$31,527
Adult Day Care	\$32,934	\$30,900	\$55,220	\$24,320
Homemaker Aide Services	\$77,608	\$92,223	\$112,964	\$20,741
Community Residential Care	\$13,745	\$12,205	\$12,669	\$464
Home Respite	\$41	\$6,394	\$13,273	\$6,879
Home Hospice	\$38,070	\$22,560	\$35,711	\$13,151
Total H & C-B	\$340,997	\$382,918	\$514,989	\$132,071

■ Capital Asset Realignment for Enhanced Services (CARES) and VA Long-Term Care

The CARES Commission found that VA has not yet developed the forecasts and policies needed to project and plan to meet future demands for long-term care. The commission made several recommendations concerning how VA should address long-term care while implementing CARES.

The CARES Commission's central recommendation was that VA develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliaries, residential treatment facilities, and nursing homes, and facilities for seriously mentally ill veterans. The commission further recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible and identifying freestanding nursing homes as an acceptable care model. Pending completion of VA's long-term care strategic plan, the commission recommended that VA only proceed with long-term care projects that make necessary life safety and maintenance improvements to existing facilities.

The Secretary's response to the CARES Commission's recommendations was supportive and indicates that VA will move forward to formulate the forecasts and policies necessary to implement a strategic plan that will address consistency of access to care across VA's health-care system. Also, the Secretary's response noted the importance on keeping veterans in need of long-term care in the least restrictive setting possible—allowing them to remain in their homes and close to their families, but recognizing that many veterans will

need inpatient nursing home and inpatient mental health care.

The Independent Budget recommends that VA immediately proceed with the development of its strategic plan for long-term care. The decade of increased demand for long-term care is already upon VA, and the development of the necessary models to analyze workload and project long-term care demand should already have been created. Nevertheless, this work must be of the first priority. *The Independent Budget* calls upon VA to thoroughly explain its current waypoint regarding various modeling techniques and to provide a timetable for the publication of its long-term care strategic care plan.

■ Long-Term Care for Veterans with Spinal Cord Injury or Disease (SCI/D)

Both institutional and noninstitutional VA long-term care services are designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with these conditions are especially vulnerable and require a high degree of long-term and acute care coordination.

Veterans with SCI/D who require VA institutional long-term care services require specialized care from specifically trained professional long-term care providers. These veterans have complex acuity needs and require an environment that is architecturally designed to meet their specific needs. These facilities must be staffed by personnel trained in the specialties of SCI/D care.

VA's CARES initiative has called for the creation of additional long-term institutional care beds in four locations across America. This is an opportunity for VA to refine the paradigm for SCI/D long-term care facility design and to develop a SCI/D long-term care staff training program. Additionally, VA should work with the Paralyzed Veterans of America to develop staffing guidelines for VA long-term care facilities and create a "SCI/D Long-Term Care Handbook" that identifies the operational policies of SCI/D long-term care.

■ Summary

VA's Office of Geriatrics and Extended Care must make every effort to ensure the availability and quality of its institutional and noninstitutional long-term care programs to meet the increasing veteran demand for these services. According to the GAO, "VA will experience a significant increase in long-term care need over the next decade because of the aging veteran population."

Despite this GAO prediction, and mandating legislation by Congress, VA has once again failed to meet the average daily census mandate of P.L. 106-117, "The Veterans Millennium Health Care and Benefits Act of 1999." Additionally, when viewed systemwide, many of VA's long-term care services are provided in a haphazard manner. The provision of each program in the long-term care benefit package is not provided in a uniform fashion across VA, and access to these programs is further complicated by individual facility interpretation of eligibility rules. Long-term care program tracking measures need to be improved and new ones developed so VA can better understand the quality of services veterans are receiving in community and state veterans' nursing homes.

Congress must also shoulder its fair share of responsibility for VA's long-term care problems. Mandating benefits and levels of service without providing VA with the necessary financial resources to achieve these goals has been a recipe for failure. Without adequate resources VA has been forced to pit one long-term care program against another, often at the veterans' expense.

VA would also like Congress to amend the Mill Bill's capacity mandate by allowing VA to count nursing home care furnished by private providers and state veterans' homes. VA's 2005 budget submission evidence VA's desire to further reduce in-house nursing

home capacity and fall further behind the congressional capacity mandate. These disturbing trends make veterans and the organizations that represent them question VA's commitment to its aging veterans.

The challenges associated with an aging veteran population have been well known for more than a decade. VA and other federal agencies were acutely aware, as early as the 1980s, that a surge of long-term care demand was coming. It is discouraging that at the beginning of the 21st century, when millions of aging veterans desperately need long-term care, that VA has not adequately prepared to meet their needs.

Recommendations:

Congress must provide the resources necessary for VA to meet the capacity mandate and provide all of the long-term care services required by P.L. 106-117 (Mill Bill).

VA must ensure that it provides comprehensive coverage of all mandated long-term care services in each VA facility.

VA must meet the congressional long-term care institutional care capacity mandate contained in the Mill Bill.

Congress must not allow VA to restructure the Mill Bill capacity mandate to include average daily census numbers from community and state veterans' nursing homes.

VA must develop adequate tracking measures to monitor quality and access to community and state veterans' nursing homes.

VA must refine its data collection efforts to eliminate service gaps in the delivery of its institutional and noninstitutional long-term care programs.

VA must promptly comply with the CARES Commission's and the Secretary's final CARES decision recommendation that it develop a long-term care strategic plan as soon as possible.

VA must develop a staff training program for long-term care professionals providing institutional care to veterans with SCI/D.

VA should work with the Paralyzed Veterans of America to develop staffing guidelines for SCI/D long-term care facilities.

VA must improve its SCI/D long-term care facility design to meet the needs of an aging veteran population.

VA must develop a new VA "SCI/D Long-Term Care Handbook" that identifies the operational policies and procedures for this specialized venue of care.



VA MEDICAL AND PROSTHETIC RESEARCH

Funding for Medical and Prosthetic Research

Funding for the Department of Veterans Affairs (VA) Medical and Prosthetic Research is inadequate to support the full range of programs needed to meet current and future health challenges facing veterans. Additionally, VA's aging research facilities are in urgent need of maintenance, upgrades, and in some cases, total replacement.

VA medical and prosthetic research is a national asset that attracts high-caliber clinicians to practice medicine and conduct research in VA health-care facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

Focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population, VA research is patient oriented. Sixty percent of VA researchers treat veterans. As a result, the Veterans Health Administration (VHA), which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science directly to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment

to steady and sustainable growth in the annual research and development (R&D) appropriation is necessary for maximum productivity.

The annual appropriation for the Medical and Prosthetic Research Program, which makes this leveraging and synergy possible, relies on an outdated funding system. A thorough review of VHA research funding methodology, including the adequacy and distribution of the Veterans Equitable Resource Allocation (VERA) research allocation, is needed to ensure sufficient funds for both the direct and indirect costs of all aspects of this world-class research program. The Office of Research and Development (R&D) allocates R&D funding for the direct costs of projects, while indirect costs and physicians' and nurses' salaries are covered by the medical care appropriation, with no centralized means to ensure that each facility research program receives adequate support.

For decades, VA has failed to request, and Congress has failed to mandate, construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in

need of minor and major construction funding. Congress and VA must work together to establish a funding mechanism designated for research facility

maintenance and improvements, as well as at least one major research construction project per year, until this backlog is addressed.

**Medical and Prosthetic Research
(in thousands)**

FY 2005	\$402,3483
FY 2006 Administration Request	393,000
FY 2006 <i>Independent Budget</i> Recommendation	460,000



Medical and Prosthetic Research Account:

VA needs significant growth in the annual Research and Development appropriation to continue to achieve breakthroughs in health care for its current population and to develop new solutions for its most recent veterans.

VA strives for improvements in treatments for conditions long prevalent among veterans such as diabetes, spinal cord injury, substance abuse, mental illnesses, heart diseases, infectious diseases, and prostate cancer. VA is equally obliged to develop better responses to the grievous conditions suffered by Iraq War veterans, such as multiple amputations, compression injuries, and stress disorders.

Recommendation:

The Independent Budget veterans service organizations recommend an FY 2006 appropriation of at least \$460 million to support a major initiative in pre- and post-deployment health issues as well as the development of improved prosthetics and strategies for rehabilitation from traumatic injuries. Additionally, the appropriation must offset the higher costs of established research resulting from biomedical inflation and wage increases.



Medical and Prosthetic Research Issues**A Clear Vision for VA Research:**

The Department of Veterans Affairs (VA) research program is in need of a thorough review and long-term planning involving external stakeholders.

During 2004 the VA research program recovered from the previous year's turmoil while VA researchers added to their remarkable record of achievement. Now there is a need to build a broad consensus about the purpose and scope of the VA research program.

Recommendation:

VA should charge the National Research Advisory Council and the Field Research Advisory Council with conducting a thorough review of the VA research program and proposing to the Secretary and Congress a clear vision for the future with recommendations on complex policy matters in need of resolution.

**Restructuring the Research Funding Methodology:**

A thorough review of the Veterans Health Administration research funding methodology is needed to ensure adequate funds for both the direct and indirect costs of this world-class research program.

With the agreement of *The Independent Budget* veterans service organizations, Congress has chosen not to assign to the Office of Research and Development responsibility for administering the Veterans Equitable Resource Allocation (VERA) research support funds. However, ensuring adequate, accountable funding for both the direct and indirect costs of research is an essential factor in the success of any research enterprise, and the problem remains unsolved for the Department of Veterans Affairs (VA). A centralized means is needed to ensure that each facility's research program receives adequate support. At the same time, the flexibility of the current methodology at the local

level is essential to meet the variable needs of research, academic, and clinical cycles.

Recommendation:

VA must demonstrate a workable plan for administration of the VERA research allocation implementation that provides accountability while preserving the local flexibility of the current methodology. At the same time, Congress must ensure adequate resources for both the direct and indirect costs of VA's efforts to advance medical diagnosis and treatment.



Attracting and Retaining a Quality VHA Nursing Workforce:

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis.

The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has the largest nursing workforce in the country with more than 55,000 registered nurses, licensed practical nurses, and other nursing personnel. Unfortunately, VA and the country at large, are experiencing a shortage of nursing personnel. VA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also causes diversions of veterans to private sector facilities at great cost. This situation is complicated by the fact that VA has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier stays, and requires more skilled nursing care.

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis. Because the VA health-care budget has not kept up with rising health-care costs, the situation has grown more critical each fiscal year. Inadequate funding has resulted in nationwide hiring freezes. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume non-nursing duties due to shortages of ward secretaries, building management, and other support personnel. These staffing deficiencies have an impact on both patient programs and VA's ability to retain an adequate nursing workforce.

Like other health-care employers, the VHA must actively address those factors known to affect retention of nursing staff: leadership, professional development, work environment, respect and recognition, and fair compensation. In addition, it is essential that adequate funds are appropriated for recruitment and retention programs for the nursing workforce.

In 2002, the National Commission on VA Nursing was established through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing

personnel and address the future of the nursing profession within the Department. The commission considered the desired future state for VHA nursing and made recommendations to achieve that vision.

The Executive Summary of the Nursing Commission Report states:

Providing high quality nursing care to the nation's veterans is integral to the mission of the Department of Veterans Affairs. The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the health-care needs of those who have served our nation. The men and women of the uniformed services who have defended our nation's freedoms in global conflicts deserve the best treatment our nation can provide. Nurses comprise the largest proportion of health-care providers in the Department of Veterans Affairs. Action is required now to address underlying issues of nursing shortage and retention while simultaneously implementing strategies that assure the availability of a qualified nursing workforce to deliver care and promote the health of America's veterans in the future.

Simultaneously, the Office of Nursing Service developed a strategic plan to guide national efforts to advance nursing practice within the VHA and engage nurses across the system to participate in shaping the future of VA nursing practice. This strategic plan embraces six patient-centered goals. These goals encompass and address many of the recommendations of the VA Nursing Commission, as well as the findings in current literature.

- **Leadership Development:**
This goal focuses on supporting and developing new nurse leaders and creating a pipeline to continuously "grow" nursing leaders throughout the organization. The objective is to operationalize the high performance development model for all levels of nursing personnel. This goal also addresses issues related

to the nursing professional qualification standards and the Nurse Professional Standards Board as discussed in the commission report.

- **Technology and System Design:**
This goal focuses on creating mechanisms to obtain and manage clinical and administrative data to empower decision making. The objective is to develop and enhance systems and technology to support nursing roles. The commission report highlighted the importance of nursing input in the development stage of new technologies for patient care.

- **Care Coordination and Patient Self-Management:**
This strategic goal focuses on promoting and recognizing innovations in care delivery and facilitating care coordination and patient self-management. The objectives are to strengthen nursing practice for the provision of high-quality, reliable, timely, and efficient care in all settings and to enhance the use of evidence-based nursing practice. This goal also encompasses recommendations from the commission related to the work environment of VA nurses.

- **Workforce Development:**
This goal focuses on improving the recognition of and opportunities for the VA nursing workforce. Areas of emphasis are
 - (1) **utilization:** to maximize the effective use of the available workforce;
 - (2) **retention:** to retain a qualified and highly skilled nursing workforce;
 - (3) **recruitment:** to recruit a highly qualified and diverse nursing staff into the VHA; and
 - (4) **outreach:** to improve the image of nursing and promote nursing as a career choice through increased collaboration with external partners.

This goal also includes an emphasis on the importance of striving for the values exhibited by the philosophy of the Magnet Recognition Program of the American Nurses Credentialing Center. The commission report addresses all of these areas as critical to the future of VA nursing.

- **Collaboration:**
This goal focuses on forging relationships with professional partners within VA, across the

federal community, and in public and private sectors. The objective is to strengthen collaborations in order to leverage resources, contribute to the knowledge base, offer consultation, and lead the advancement of the profession of nursing for the broader community. The priorities of this goal align with the VHA's Vision 2020 and the commission recommendations related to collaboration and professional development.

- **Evidence-Based Nursing Practice:**
This goal focuses on identifying and measuring key indicators to support evidence-based nursing practice. The objective is to develop a standardized methodology to collect data related to nursing sensitive indicators of quality, workload, and performance within VHA facilities, which will be integrated into a standardized national database. The commission report applauded VA's progress to date related to this goal.

The Independent Budget veterans service organizations (IBVSOs) support the commission's recommendations and the strategic plan of VA's Office of Nursing Services. The IBVSOs strongly urge Congress to develop a budget for VA health care that will allow the VHA to invest resources—human, fiscal, and technological—for recruiting and retaining nurses and proactively testing new and emerging nursing roles. The commission's legislative and organizational recommendations are a blueprint for the reinvention of VA nursing. The VA model will serve as a foundation for the creation of a care delivery system that meets the needs of our nation's sick and disabled veterans and those providing their care.

At the end of the 108th Congress, two measures were enacted that signal a good start to addressing medical personnel recruitment and retention issues in general and the nursing shortage in particular. The first measure would have simplified and improved pay provisions for physicians and dentists and authorizes alternative work schedules and executive pay for nurses. The second measure would have established a pilot program to study the use of outside recruitment, advertising and communications agencies, and interactive and online technologies, to improve VA's program for recruiting nursing personnel.

Recommendations:

VA should establish recruitment programs that enable VA to remain competitive with private-sector marketing strategies.

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

Volunteer Programs:

The Veterans Health Administration's (VHA) volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 663.5 million hours of volunteer service to America's veterans in VA health-care facilities. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of 63 major veteran, civic, and service organizations, which reports to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2004, VAVS volunteers contributed a total of 12,951,337 hours to VA health-care facilities. This represents 6,206 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than \$223 million if VA had to staff these volunteer positions with FTEE employees.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The annual contribution made to VA is estimated at \$42 million. These significant contributions allow VA to assist direct patient care programs, as well as

support services and activities that may not be fiscal priorities from year to year.

Monetary estimates aside, it is impossible to calculate the amount of caring and sharing that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are being placed on VA staff. Health care is changing, which provides opportunity for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that the VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 287,000 volunteer hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

Recommendation:

VHA facilities should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

Contract Care Coordination:

The Department of Veterans Affairs (VA) does not ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private community-based providers at VA expense.

To ensure a full continuum of health-care services, it is critical that VA implement a program of contract care coordination that will, for the first time, include integrated clinical and claims information for both veterans receiving care within VA facilities and for those receiving some or all of their care in the community. VA currently spends approximately \$2 billion a year on purchased care outside the walls of VA but is not able to track the care, related costs, outcomes, or veteran satisfaction. Current legislation allows VA to contract for non-VA health care (fee basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. Unfortunately, no consistent process exists in VA for veterans receiving contracted-care services to ensure that

- (1) effective care delivered by certified or credentialed providers;
- (2) continuity of care is properly monitored by VA and that veteran patients are directed back to the VA health-care system for follow-up care when possible;
- (3) veterans' medical records are properly updated with any non-VA medical and pharmaceutical information; and
- (4) the process is part of a seamless continuum of care/services to facilitate improved health-care delivery and access to care.

Currently, the Preferred Pricing Program allows VA to reap savings when veterans who need contracted care select a physician within the established Preferred Provider Organization (PPO) network. Preferred pricing allows contracted VA medical facilities to save money when veterans need non-VA health-care services by using network discounts. However, VA's program for contracted care is *passive* and only allows for cost savings when veterans coincidentally *choose* to receive care from the contractor's provider network.

VA currently has no system in place to direct veteran patients to the participating PPO providers so VA can

- (1) receive a discounted rate for the services rendered;
- (2) use a mechanism to refer to credentialed, quality providers; and
- (3) exchange clinical information with non-VA providers. Although preferred pricing is available to all VA medical centers (VAMCs), not all facilities take advantage of these cost savings.

Therefore, in many cases, VA is paying more for contracted medical care than necessary. Though preferred pricing was a significant improvement in purchasing care for the best value when it was introduced in 1999, and despite the significant savings achieved (more than \$34 million), there are several major improvements that can be made to improve the access, quality, and cost of non-VA care.

By partnering with an experienced managed-care contractor, VA can define a care-management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value.

Components of the program would include the following:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks would address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor would require providers to meet specific requirements, such as the timely communication of clinical information to VA, electronic claims submission, meeting VA established access standards, and complying with directors' performance measures.
- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the

appropriate non-VA care to the veteran's medical condition, the care-coordination contractor addresses appropriateness of care and continuity of care. The result for the veteran is an integrated episode of care.

- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.
- Best value health-care purchasing.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating PPO physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care. A care-coordination contractor could be used to temporarily fill a gap or deal with unexpected backlogs. Prior to the implementation of the Capital Asset Realignment for Enhanced Services plan, it is important for VA to develop an effective care-coordination model that achieves its health-care and economic objectives. Doing so will improve patient care quality; optimize the use of VA's increasingly limited resources, and prevent overpayment when utilizing community contracted care.

Recommendations:

VA should establish a phased-in, contracted-care coordination program that is based on principles of medical management.

Whenever possible, veterans who receive care outside VA, at VA expense, should be required to do so in the care coordination model.

VA should engage an experienced contractor—willing to go at risk—to implement and manage a care-coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor would jointly develop identifiable and achievable metrics to assess program results and would report these results to stakeholders.

Components of a care-coordination program should include claims processing, centralized appointment scheduling, and a call center or advice line for veterans who receive care outside the VA health-care system—and should be implemented at VA's expense.



Administrative Issues

Veterans Affairs Physician Assistant:

The position of physician assistant advisor to the Under Secretary of Health should be a full-time employee equivalent (FTEE).

The Department of Veterans Affairs (VA) is the largest single federal employer of physician assistants (PAs), with approximately 1,524 full-time PA FTEE positions. Since the "Veterans Benefits and Health Care Improvement Act of 2000" (PL. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, VA has continued to assign this duty as a part-time position as a PA in addition to his or her other duties. *The Independent Budget* has requested for

four years that this be a full-time FTEE in the Veterans Health Administration, and in Senate Appropriations language in 2003 it was requested and ignored. VA has refused to establish this important FTEE as full time, and despite numerous requests from members of Congress and the veterans service organizations, has maintained this position as a field-based one with a very limited travel budget.

PAs in the VA health-care system were the providers for more than 8,500,000 veteran visits in FY 2003, and PAs work in primary care, ambulatory care clinics, and in 22 other medical and surgical specialties. PAs are a vital part of VA health-care delivery and should have the PA advisor included in VA Central Office as a full-time FTEE in very close proximity to Washington, DC, which was the intent of the law. We urge Congress to fund this FTEE within the VA budget for

FY 2006 and to ensure this position is based in Washington, DC.

Recommendation:

Congress should legislatively mandate that the position of physician assistant advisor be a full-time FTEE within VA's budget for FY 2006.

Construction Programs

The Department of Veterans Affairs (VA) construction budget includes major construction, minor construction, grants for construction of state extended-care facilities, and grants for state veterans' cemeteries. VA's construction budget annual appropriations for major and minor projects decreased sharply to an all-time low in fiscal year 2003 (FY 2003). Over the past several years there has been political resistance to funding of any major projects before the Capital Assets Realignment for Enhanced Services (CARES) process was completed. The prospect of systemwide capital assets realignment through the CARES process continues to be used as an excuse to hold all construction projects hostage.

VA has recently completed another phase of CARES, which is a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through CARES, an ongoing process, VA is evaluating the demands for health-care services and identifying changes that will help meet veterans' current and future health-care needs. The CARES process included the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the supply and identification of current and future gaps in infrastructure capacity. This resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure.

Since the publication of the FY 2005 *Independent Budget (IB)*, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The Secretary of Veterans Affairs formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, the DNCP market plans included flawed projections for outpatient mental health services and questionable projections for inpatient mental health services. The plans did not include any projections for long-term care other than catastrophic care. Accordingly, the commission recognized the importance of mental health services and long-term care to the veteran population and acknowledged in the CARES Commission report that VA must make modifications to its projections to include mental health services and long-term care.

Also last year, during the initial stages of the CARES process, *The Independent Budget* veterans service organizations (IBVSOs) suggested that further data be obtained to support various CARES recommendations that would either close or change the mission of some VA facilities. We appreciate the Secretary's efforts in establishing a CARES Implementation Board and the plan to begin further feasibility studies of the 22 VA facilities identified for possible mission adjustments in the Secretary's CARES decision document. However, as stakeholders, we would like to remind VA that it is imperative that veterans service organiza-

tions remain involved in all phases of this new CARES study, which will be divided into three different segments: a health-delivery study, a comprehensive capital plan, and an excess property plan identifying new land usage or disposal.

We remain supportive of the CARES process as long as the primary emphasis is on the “ES” portion of the acronym. We still understand that the locations and missions of some VA facilities may need to change to improve veterans’ access, to allow more resources to be devoted to medical care rather than to the upkeep of inefficient buildings, and to accommodate modern methods of health-service delivery. Accordingly, we

concur with VA’s plan to proceed with the feasibility study of the remaining 22 facilities contained in the Secretary’s decision document.

The IBVSOs also remain concerned that Congress may not adequately fund all CARES proposed changes when CARES implementation costs are factored into the appropriations process. This will only further exacerbate the current obstacles impeding veterans’ timely access to quality health care. It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated for the construction of new facilities and renovations of existing hospitals, as deemed appropriate and pertinent.

MAJOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate \$563 million to the major construction account for FY 2006. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Construction, Major Appropriation FY 2006 IB Recommendation

CARES.....	\$408,750
Advanced Planning Fund (VHA)	30,000
Asbestos Abatement	5,000
Claims Analyses.....	2,000
Judgment Fund	10,000
Hazardous Waste.....	2,000
NCA	85,050
Design Fund.....	5,000
Advanced Planning Fund	10,000
Staff Offices	5,000
<i>Total, Major Construction</i>	<i>\$562,800</i>



MINOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate \$716 million to the minor construction account for FY 2006. These funds contribute to construction projects costing less than \$7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, staff offices account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Construction, Minor Appropriation FY 2006 Recommended

CARES	\$263,000
Non-CARES	100,000
Seismic	150,000
NCA	30,000
VBA	36,000
Staff	5,000
Advanced Planning Fund	10,000
IG	1,000
Historic Preservation Grant Program	25,000
Architectural Master Plans Program	100,000
Total, Minor Construction	\$720,000



CONSTRUCTION ISSUES

Inadequate Funding and Declining Capital Asset Value

The Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs—such as seismic correction, compliance with the Americans With Disabilities Act (ADA) and Joint Commission of Accreditation of Health Care Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES—VA's construction budget continues to be inadequate.

The Independent Budget for Fiscal Year 2005 cited the recommendations of the interim report of the Presi-

dent's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we again cite the recommendations of the PTF:

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only \$246 million annually, a recapitalization rate of 0.64 percent of the \$38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA

invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the Department of Defense adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

The PTF also recommended that “an important priority is to increase infrastructure funding for construction, maintenance, repair and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure.”

The PTF also indicated, “Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus but instead submits an annual top 20-facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program.”

The PTF believes that VA must accomplish three key objectives:

- (1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health-care delivery;
- (2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and
- (3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

The Independent Budget veterans service organizations concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Recommendation:

Congress must ensure that there are adequate funds for the major and minor construction programs so the VHA can undertake all urgently needed projects.



What Should Follow CARES:

The Department of Veterans Affairs (VA) must immediately undertake certain activities in order to secure the potential benefits of the Capital Asset Realignment for Enhanced Services (CARES).

The CARES long-range planning study is now complete, and the time is at hand to initiate a major construction program to enhance VA's medical facilities. The CARES study has attempted to forecast the future demand for services and identify what patient programs will be most needed. The study has also proposed realignments of existing assets to best meet these needs. During past years, construction funding has been frozen pending the CARES outcome. This expenditure reduction has been detrimental to the

maintenance of VA's capital assets and has caused atrophy in the construction management program. Construction planning has now restarted, and an enhanced program should be implemented in an efficient and deliberate manner.

In order to initiate this new era of expanded construction, VA must establish a national program of architectural master plans that describe the most efficient means of implementing CARES medical initiatives. In

addition, VA needs to establish a management mechanism that collects, maintains, and evaluates critical planning data. This new system should monitor CARES forecasts and adjust their conclusions as events unfold. Inaccurate forecasts cannot be allowed to remain uncorrected, as was the case with Medical District Initiated Planning Process (MEDIPP) in the late 1990s. Statistical data for the three medical programs (long-term care, mental health, and domiciliary) that were omitted from CARES should be added as quickly as possible.

VA must internally coordinate its planning, construction, and management responsibilities. Better long-range planning needs to be coupled with shorter design and construction time frames in order to deliver a better product in a more efficient manner. Comprehensive solutions need to be developed for aspects of

their facility inventory that were not addressed by CARES. These include VA historic properties and the vacant space that exists at many medical centers.

Recommendations:

VA construction should be expanded in order to meet the system's current and projected space needs.

VA must initiate new programs for architectural master planning based on the CARES recommendations.

VA must maintain and analyze new planning data and streamline the current design and construction process.

VA must develop programs to address historic properties and vacant space.



Establishing a Program for Architectural Master Plans for Medical Centers:

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed architectural master plan.

This year's construction budget should include \$100 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty construction planning.

Currently VA plans construction in a reactive manner—i.e., funding the project and then fitting it on the site. There is no planning that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into a corner. If all projects are not simultaneously planned, the first project may be built in the best site for the second project. The development of master plans will prevent short-sighted construction that restricts, rather than expands, future options.

Every new project is a step in achieving the long-range CARES objectives. Master plans must be developed so that each project can be prioritized, coordinated, and phased. Phasing to avoid disrupting medical care can be a substantial project expense. Architectural master

planning will allow preparation of more accurate cost estimates, which include contingency expenses for phasing. Cost estimates prepared during master planning will either validate, or challenge, the original CARES decisions. For example, if CARES called for use of renovated space for a relocated program and a more comprehensive examination indicates that the selected option is impractical, other options should be considered.

Some CARES plans involve projects constructed at more than one medical center. Master plans must coordinate the priorities of both medical centers. For example, construction of a new SCI facility may be a high priority for the "gaining" facility, a low priority for the "donor" facility. It may be best to fund the two actions together, even though they are split between two medical centers. Architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care.

In order to initiate architectural master planning, VA must establish formats for contracted architects to develop physical plans based on programmatic and operational decisions agreed to during CARES. Architectural master planning must begin immediately in order to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction. VA should already have developed a master planning program as recommended in *The Independent Budget for Fiscal Years 2004 and 2005*.

Recommendations:

Congress must appropriate \$100 million for medical center master plans in the fiscal year 2006 construction budget.

The facility master plans should address the long-term care, severe mental illness, and domiciliary care programs. Architectural master plans should also address historic properties and vacant space.

VA must quickly develop a format for these master plans so there is standardization throughout the system, even though the planning work will be performed in each Veterans Integrated Service Network by local contractors. The format should be tested in pilot projects.



Better Coordinate Planning and Design Time Frames in Order to Efficiently Manage Construction:

The Department of Veterans Affairs (VA) must develop realistic and compatible time frames for use in the Capital Asset Realignment for Enhanced Services (CARES) initiative, facility master planning, and individual project development.

The VA project development process from design initiation to building occupancy takes from 8 to 10 years. The duration of the process cannot be ignored as a factor in evaluating CARES planning initiatives. There is an inherent incompatibility between the 17-year, long-range planning process and the 10-year implementation process. The development process will increase as a result of CARES. The current project timeline does not include a master planning step. In addition, many CARES projects will require more complex construction phasing, and some may even involve private-sector real estate transactions.

Even if master planning were initiated immediately, occupancy of the first CARES project would occur more than a decade later. As a practical matter, one must assume that the majority of CARES projects will not be completed by 2022, the second CARES planning target date. Only a very few projects will be completed by the first 2012 target date. As a conse-

quence of these long time frames, CARES plans must be viewed in a different light. For example, higher demand for veterans' services that are projected for 2012 must be addressed by nonconstruction alternatives. There is simply not sufficient time to construct new facilities to meet the forecasted need. VA should address these responsibilities by means of operational adjustments.

In order to properly manage construction, VA must coordinate cycles for medical planning, architectural master plans, and project design. Statistical data gathering, for example, should be conducted every year. Now that CARES planning tools have been adopted, the same data format should be updated annually. This will allow VA to monitor previous projections. For example, was the CARES demand forecast for services accurate? If not, why not? This analysis will also allow VA to improve future long-range planning.

Comprehensive systemwide planning (like CARES) should be conducted on a 10-year cycle, but updated each year. Architectural master planning should be conducted on the same cycle as comprehensive medical planning but should be adjusted every three years to reflect changes in demand for services, philosophy of care, and new medical technologies. VA should reduce the length of the design and construction process so that newly completed facilities reflect the current planning data, the most advanced medical technologies, and the newest models for patient care. Health-care advances occur at much too swift a pace to be compat-

ible with a long, inflexible design and construction process.

Recommendations:

VA must develop nonconstruction alternatives to enable it to meet the projected increased demand for veterans' health-care services in the year 2012.

VA should conduct both medical program and architectural master planning on a regular cycle that is appropriate for each activity.



Congress Must Appropriate Sufficient Construction Funding Each Year in Order to Steadily Implement Planning Initiatives:

Using CARES statistical data in facility management and budgeting.

The Department of Veterans Affairs (VA) and Congress should make full use of the data produced by the Capital Asset Realignment for Enhanced Services (CARES) initiative.

The CARES study has produced new data that are potentially useful to Congress and VA. The study paints a statistical picture of the system's current deficiencies in functional space. By the application of planning algorithms, current space requirements have been mathematically computed for every medical program (except long-term care, mental illness, and domiciliary). This computation establishes a "benchmark" that is compared to existing space inventories. The mathematical difference between the benchmark and the inventory represents the deficiency. This is the net amount of new construction needed to provide quality medical care to today's veterans. Using this data, a specific medical center, for example, can be identified as the "most deficient" in the VA system. By extension, this facility is "most in need of new construction." Medical programs can also be compared on a similar basis.

CARES data will also allow prioritization (ranking) of construction funding, based on a variety of criteria, such as geographic regions or medical programs. Because these data are based on completely objective

measurements, they are not the product of any assumptions regarding future needs.

The data that are based on more fragile forecasts are "projected space deficiencies." These are based on various planning postulates regarding veteran eligibility, population demographics, and future military actions. Actuarial data are used to project these future demands for veterans' health-care services. Because of these conjectures, the forecasts are less firm than existing deficiencies. These projections must be considered, however, because VA must plan for the system's future needs. Long-range planning is particularly critical for construction because of the length of the implementation process.

The CARES data illustrate the scope of both the system's current and future construction needs. These data can be used to establish the magnitude of construction budgets and provide a rational basis to distribute these resources. Allocations, for example, could be made to address the greatest current space deficiencies. Alternatively, funding could be prioritized to offset the greatest projected space needs. Budgets could be adjusted to emphasize one medical program over another. VA should have been collecting such data for decades for the purposes of system management and congressional oversight.

With the new CARES data, better systemwide facility management is now possible. The CARES data should therefore be periodically updated in order to verify the accuracy of the underlying assumptions and make the necessary adjustments to facility and operational plans. Similar statistical data should be generated for the three missing programs (long-term care, mental illness, and domiciliary).

Recommendations:

VA should generate similar CARES statistical data for long-term care, severe mental illness, and domiciliary.

VA should use CARES data to establish the magnitude of construction that is required to address current space deficiencies.

VA should use CARES data to identify future space deficiencies, and initiate construction now, to meet future needs.

VA should use the deficiencies data to establish current and future construction budgets and to allocate these resources among the various medical centers and medical programs.

VA should periodically update the CARES data as an important tool for systemwide planning and management.



Updating and Expanding VA Design Guides:

The Department of Veterans Affairs (VA) must develop long-term care facility design guides for spinal cord injury (SCI) patients.

VA owns and operates the largest health-care system in the United States. An advantage of this role is the ability to develop, evaluate, and refine the design and operation of their many facilities. Every new clinic's design, for example, should benefit from lessons learned from previous clinics. VA should collect input from facility operators, such as medical staff and engineering officers, and also from users, including patients and their families. This feedback should generate improvements to future designs.

VA currently provides design guides for some facilities that support veterans' care. The guides are tools used by the designer, clinician, staff, and management during the design process. Currently, there are no design guides for long-term care facilities. The only available guide for extended care facilities is the 1990 VA Handbook 7610 Chapter 106, "Nursing Home Care Units." However, the data are limited, omitting such figures as square footage requirements for functional spaces. VA is currently preparing a new design guide for extended-care facilities. This design guide

will specifically address the needs of aging patients who require varied levels of medical care. Even at the 50 percent completion level, the guide appears to have the necessary elements to build successful extended-care facilities.

The Capital Asset Realignment for Enhanced Services process advocates construction of several new long-term care SCI centers. Design guides for long-term spinal cord injury facilities must also be developed immediately. Currently, long-term care facilities utilize the same design concepts as acute-care facilities. This approach is not appropriate. Long-term care facilities should not provide the same patient environment as acute-care centers. Although they need to meet specialized accessibility criteria, they should be less institutional in their character with a more homelike environment. Rooms and communal spaces should be designed to accommodate patients who will live in these facilities for extended periods of time. Simple ideas that would make daily living more residential should be included. For example, corridor lengths

should be limited and should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyards in areas where the climate is temperate or indoor solariums where it is not. A complete guideline for these facilities would also include a discussion of design philosophies as well as specific criteria for each space.

Care for the long-term SCI patient results from primarily physical issues, not aging or mental health. An SCI long-term care patient could be a 19-year-old newly injured veteran or a 75-year-old veteran who has been a wheelchair user for decades. Both may be in a long-term

facility due to a medical acuity, or they may not have the family support available to aid them. Because this type of care is unique, it is particularly important the design guidance be available to contracted architects.

Recommendations:

VA should continue to create extended-care design guides and to update guidelines for nursing home care.

VA should quickly develop specialized long-term care design guides for SCI patients.



Preservation of VAs Historic Structures:

The Department of Veterans Affairs' (VA) extensive inventory of historic structures must be protected and preserved.

VA's historic structures illustrate America's heritage of veterans' care, and they enhance our understanding of the lives of the soldiers and sailors who have shaped our country. Of the almost 2,000 historic structures VA owns, many are neglected and deteriorate further every year. These structures must be stabilized, protected, and preserved. As the first step in addressing this responsibility, VA must develop a comprehensive national program for its historic properties. Because most heritage structures are not suitable for modern patient care, the Capital Asset Realignment for Enhanced Services planning process did not produce a national preservation strategy. VA must undertake a separate initiative for this purpose immediately.

VA must inventory its historic structures, classify their current physical condition, and evaluate their potential for adaptive reuse by either the medical centers, local governments, nonprofit organizations, or private-sector businesses. To accomplish these objectives, we recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and also with private organizations, such as the National Trust for Historic Preservation. Such expertise should prove helpful in establishing this new

program. VA must also expand its limited preservation staffing.

For its adaptive reuse program, VA needs to develop models and policies that will protect historic structures that are leased or sold. VA's legal responsibilities, for example, could be addressed through easements on property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully assisted the Department of the Army in managing its historic properties.

We applaud the passage of HR 3936, which establishes a revolving fund for costs associated with transfer, renovation, or leasing these facilities. We propose a \$25 million budget for FY 2006 for this fund in VA's activities related to veterans' facilities.

Recommendation:

Specific funds should be included in the FY 2006 budget to develop a comprehensive program with detailed responsibilities for the preservation and protection of VA's inventory of historic properties.

Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs (VA) should avoid the temptation to reuse empty space inappropriately.

Studies have suggested that the VA medical system has extensive empty space that can be cost-effectively reused for medical services, and that one medical center's unused space may help address another's deficiency. Although these space inventories are accurate, the basic assumption regarding viability of space reuse is not.

Medical design is complex because of the intricate relationships that are required between functional elements and the demanding requirements of equipment that must be accommodated. For the same reasons, medical facility space is rarely interchangeable. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a second-floor space deficiency because there is no functional adjacency. Medical space has very critical inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care. In order to preserve these relationships, departmental expansions or relocations usually trigger "domino" effects on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Medical space's permanent features, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading cannot be altered. Different medical functions have different requirements based on these characteristics. Laboratory or clinical space, for example, is not interchangeable with ward space because of the need for different column spacing and perimeter configuration. Patient wards require natural light and column grids that are compatible with room layouts. Laboratories should have long structural bays and function best without windows. In renovation, if the "shell" space is not suited to its purpose, plans will be larger, less efficient, and more expensive.

Using renovated space rather than new construction only yields marginal cost savings. Build out of a "gut" renovation for medical functions is approximately 85 percent of new construction cost. If the renovation plan is less efficient or the "domino" impact costs are greater, the savings are easily lost. Remodeling projects often cost more and produce a less satisfactory

result. Renovations are appropriate to achieve critical functional adjacencies, but they are rarely economical.

Early VA centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most hospitals have been consolidated into large, tall "modern" structures. Over time, these central towers have become surrounded by radiating wings with corridors leading to secondary structures. Many medical centers are built around prototypical "Bradley buildings." The VA rushed to build these structures in the 1940s and 1950s for World War II veterans. Fifty years ago, these facilities were flexible and inexpensive, but today they provide a very poor chassis for the body of a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to-floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts. The Bradley hospital's central core has a few small elevator shafts that are inadequate for vertical distribution of modern services.

Much of the current vacant space is not situated in prime locations but is typically located in outlying buildings or on upper floor levels. The permanent structural characteristics of this vacant space often make it unsuitable for modern medical functions. VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved. Some space may be suitable for enhanced use. Some should be demolished. Each medical center should develop a plan to find suitable uses for its nonhistoric vacant properties.

Recommendation:

VA should develop a comprehensive plan for addressing excess space in nonhistoric properties that is not suitable for medical or support functions due to its permanent characteristics or location.

Vocational Rehabilitation and Employment

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or re-entry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties in turn contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years, there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases, these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to eliminate licensing requirements and employment barriers. We are encouraged by the emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) program, Department of Veterans Affairs (VA) Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E program. *The Independent Budget* supports the recommendations of the task force, and we look forward to seeing these recommendations implemented.

Vocational Rehabilitation and Employment Issues

Services for Disabled Veterans Lacking:

Many disabled veterans are not receiving suitable vocational rehabilitation and employment services required to provide a smooth transition into the workforce.

On January 10, 2000, the Department of Veterans Affairs (VA) changed the name of the Vocational Rehabilitation and Counseling Service (VR&C), to Vocational Rehabilitation and Employment Service (VR&E). The purpose of the name change was to reenergize the focus of the organization's mission, preparing disabled veterans for suitable employment and providing independent living services to those veterans who are severely disabled and are unlikely to secure suitable employment at the time of their entry into independent living. We applaud VA's efforts and look forward to their continuing changes to improve delivery of meaningful services to disabled veterans. For too many years, and in spite of many individual successes, the VR&E was the recipient of valid criticism. Many of these criticisms remain of concern, including the following:

- inadequate and sometimes nonexistent case management with lack of accountability for poor decision making;
- outdated regulations, as well as policies and procedures manuals;
- long delays in the time taken to process applications due to staff shortages and large case loads;
- inadequate use of electronic information technology;
- failure to explore entrepreneurial opportunities for disabled veterans;
- declaring veterans rehabilitated before suitable employment has been obtained;
- inadequate and inconsistent tracking of the electronic case management information system; and
- need for improved collaboration between the Department of Labor and the Small Business Administration.

In order to address the problems with the current VR&E program, the VR&E Task Force recommended a fundamental change in the program. The task force emphasized the need to have an employment-driven process, which it refers to as the Five-Track Employment Process. This new process provides the following services to veterans:

- reemployment of veterans,
- access to rapid employment services,
- self-employment,
- long-term vocational rehabilitation services, and
- independent living services.

Implementation of this new process can only improve the services that the VR&E provides. These improvements will allow veterans to obtain suitable employment necessary to leading a productive life. We are encouraged by the progress being made by the VR&E to implement the recommendations of the task force and look forward to seeing additional improvements made.

Recommendations:

VA must place a higher emphasis on complementing the VR&E's staffing requirements and needs.

The VR&E should continue its efforts to improve case management techniques and use state-of-the-art information technology.

The VR&E should rewrite its operational policies and procedure manuals.

General counsel should expedite the promulgation of new regulations for the VR&E.

The VR&E must place higher emphasis on academic training, employment services, and independent living services to achieve the goal of rehabilitation of severely disabled veterans.

The VR&E should develop plans and partnerships to enhance the availability of entrepreneurial opportunities for disabled veterans.

The VR&E should implement the Five-Track Employment Process to focus services more on achieving employment for veterans and not just training.

The VR&E should develop plans to continue follow-up of rehabilitated veterans for at least two years to ensure that rehabilitation is successful.



Unpaid Work Experience:

For vocational rehabilitation clients, the unpaid work experience program should be expanded to include work in the private and nonprofit sector.

In today's labor market, it is beneficial for those seeking career employment not only to be trained properly but also to have some related work experience, either as an intern, volunteer, or in some other capacity.

The concept of unpaid work experience as part of a veteran's training program is significant and should result in a higher success rate of employment outcomes.

For many years, disabled veteran clients under vocational rehabilitation could participate in a program of unpaid work experience as part of their rehabilitation program with federal government agencies. This authority was expanded to include state and local governments but not private or not-for-profit sector employers.

Recommendation:

Congress should extend the authority for unpaid work experience to private sector and not-for-profit sector employers who are willing to develop such unpaid work experience opportunities consistent with the veteran's training program.



Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense (DOD), Labor (DOL), and Veterans Affairs (VA) provide transition assistance workshops to separating military personnel through the Transition Assistance Program and the Disabled Transition Assistance Program. These programs generally consist of a three-day briefing on employment and related subjects, as well as veterans benefits.

DTAP, however, has been largely relegated to a “stand-alone” session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment Service (VR&E) representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). The Independent Budget veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004.

The IBVSOs are encouraged that the VR&E is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans, and we will continue to

monitor the changes and progress in the DTAP program.

Recommendations:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

VA should assign primary responsibility for the DTAP program within the Veterans Benefits Administration to the VR&E service and designate a specific DTAP manager.

The DOD should ensure that separating service members with disabilities receive all of the services provided under TAP as well as the separate DTAP session by the VR&E.

Whenever practical, the DOD should make pre-separation counseling available for members being separated prior to completion of their first 180 days of active duty unless separation is due to a service-connected disability when these services are mandatory.

**Certification and Licensing of Transitioning Military Personnel:**

Civilian licensure and certification barriers facing transitioning military members must be reduced.

In recent years, there has been an increased reliance on licensure and certification as a primary form of competency recognition. The public, professional associations, employers, and the government have turned to credentialing to regulate entry into employment and to promote safety, professionalism, and career growth. Hundreds of professional and trade associations currently offer certification in their fields, and there has been an increase in occupational regulation by both the state and federal governments. The trends

suggest that in the 21st century the interest in competency recognition will accelerate.

The emphasis on licensure and certification can present significant barriers for transitioning military personnel seeking employment in the civilian workforce. Credentialing standards, such as education, training, and experience requirements are developed based on traditional methods for obtaining competency in the civilian workforce. As a result, many tran-

sitioning military personnel who have received their career preparation through military service find it difficult to meet certification and licensing requirements because of a lack of civilian recognition of military training and experience. For some, this inability to become credentialed bars entry into employment in their fields entirely. For others, the lack of credentials will make it difficult to compete with their civilian-sector peers for jobs. Those who are able to obtain employment in their fields without the applicable credentials may face decreased earnings and limited promotion potential.

Pilot programs have been initiated in some states to provide credentialing to service members in a limited number of fields. *The Independent Budget* veterans service organizations (IBVSOs) believe that there are a number of factors that have an impact on the ability of current and former military personnel to obtain civilian credentials. Many civilian credentialing boards do not have adequate knowledge of and do not give proper recognition to military training and experience.

There is a lack of clarity regarding the procedures for exchange of transcripts between military and civilian credentialing boards that creates undue barriers for military personnel.

The IBVSOs believe the Department of Defense (DOD) must assist members preparing to transition from active duty to civilian jobs through the proper dissemination of information. The DOD must maintain involvement with the certifying organizations and coordinate efforts among federal agencies and private industry.

Recommendations:

A standardized licensure and certification requirement must be adopted by the appropriate federal and state agencies.

Recently separated service members must be afforded the opportunity to take licensing and certification exams without a period of retraining.



Performance Standards:

Performance standards in the Veterans Employment and Training Service (VETS) system are inconsistent and inadequate.

While progress is being made to implement the "Jobs for Veterans Act" (P.L. 107-288), there are still no clear performance standards that can be used to compare one state to another or even one office to another office within a state. Even where such benchmarks have been produced, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. (Given the limits of state civil service systems, some State Employment Security Agency (SESA) administrators have a similar difficulty in holding local managers accountable for performance.) The only real tools VETS possesses are the staff members' own powers of moral suasion and personal relationships they may have developed.

The only real authority is the seldom-used power to recapture funds when a state has acted in a way

contrary to law. For several years, many have seen a need for standards to be put in place for both Disabled Veterans' Outreach Program (DVOP)/Local Veterans' Employment Representative (LVER) staff and for the SESA as an entity. Beginning in 2002, VETS initiated performance measures that apply to all veterans served by the public labor exchange. These measures address the rates of entry to employment and the rates of retention in employment. In 2004 the same performance measures were applied to veterans served by the DVOP and LVER staff members. These reforms are essential to ensuring a viable job placement service. The ultimate goal is to accomplish the congressional intent and purpose as expressed in 38 U.S.C. § 4102:

The Congress declares as its intent and purpose that there shall be an effective (1) Job and Job Training Counseling Service Program,

(2) Employment Placement Service Program, and (3) Job Training Placement Service Program for eligible veterans...so as to provide such veterans and persons the maximum of employment and training opportunities.

Recommendations:

VETS must complete development of meaningful performance standards and reward states that exceed the standards by providing additional funding.

Public Law 107-288, the Jobs for Veterans Act, authorizes VETS, through grants to states, to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, find work. This recognition is only for individuals and not entities. Congress should amend this law so such entities as career one-stops who do a good job for veterans can be recognized.



Training Institute Inadequately Funded:

The National Veterans Training Institute (NVTI) lacks adequate funding to properly administer its training programs, which are unavailable elsewhere.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. The NVTI is administered by staff from the DOL/Veterans Employment and Training Service (VETS) through a contract currently with the University of Colorado at Denver. The NVTI trains federal and state employees and managers who provide direct employment and training services to veterans and service members. The NVTI curriculum offers courses for staff of the Disabled Veterans' Outreach Program and Local Veterans' Employment Representative programs in core professional skills, marketing and accessing the media, case management, vocational rehabilitation and employment program support, and facilitation of Transition Assistance Program (TAP) workshops.

Training offered to VETS staff includes a basic course on the Uniformed Services Employment and Reemployment Rights Act, enacted in October 1994, a new investigative techniques course, a quality management course, and a grants management course.

The NVTI offers Department of Defense employees TAP management training, through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center and repository for training and resource information related to veterans programs, projects, and activities.

The Independent Budget veterans service organizations are concerned that, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

Recommendation:

Congress must fund the NVTI at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.



Program Reassessment:*Leadership is needed on a comprehensive reassessment of veterans employment and training programs.*

This reassessment must involve all veterans and other stakeholders, as well as congressional oversight. The Senate and the House Veterans' Affairs Committees should take the lead in the reassessment and include veterans service organization the National Association of State Workforce Agencies, and veteran-based organizations, such as the National Coalition of Homeless Veterans and the Office of the Assistant Secretary for Veterans Employment and Training, in discussing these matters of standards and accountability for veterans employment programs.

Continuing discussions on a more effective basis for delivering employment and training services to veterans should take place. The need is to secure the best thoughts of veterans and the various stakeholders, solicit their support of general concepts, forge common ground for modifications to the law, and ensure early and effective compliance should such changes to the law be authorized and the funding appropriated.

The progressive movement toward one-stops does not diminish the role of Disabled Veterans' Outreach Program (DVOP)/Local Veterans' Employment Representative (LVER) in delivering employment services to veterans. Unless there is a paradigm shift,

there will likely be reductions in force of DVOP specialists and LVERs. The advantage of a face-to-face interaction between DVOPs/LVERs and veterans must not be eliminated.

Recommendations:

The House and Senate Veterans' Affairs Committees must conduct oversight to assure full implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills the following purposes:

- raising employer awareness of the advantages of hiring separating service members and recently separated veterans;
- facilitating the employment of separating service members and veterans through America's Career Kit, the National Electronic Labor Exchange; and
- directing and coordinating departmental, state, and local marketing initiatives.

Congress should provide the Department of Labor adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.



National Cemetery Administration

The National Cemetery Administration's (NCA) mission is to honor veterans with a dignified final resting place that exhibits evidence of the nation's gratitude for their military service. Its challenge is to provide all veterans and their families an available option for burial in a national or state veterans' cemetery.

In fiscal year 2004, the NCA maintained more than 2.6 million gravesites in approximately 14,000 acres of cemetery land and provided interments to nearly 90,000 individuals. NCA management responsibilities include 120 cemeteries: Of these, 60 have available, unassigned gravesites for burial of both casketed and cremated remains; 26 allow only cremated remains; and 34 are closed to new interments.

In addition, the NCA burial program calls for activation of six new cemeteries in the areas of Detroit, Michigan; Sacramento, California; Ft. Sill, Oklahoma; Miami, Florida; Atlanta, Georgia; and Pittsburgh, Pennsylvania. "Fast track" burials, which allow interment in a designated section of a cemetery prior to final completion of all construction activities, are already available in Oklahoma, Pennsylvania, and Florida and are planned for Michigan and Georgia in 2005. Construction funding is planned for California in the fiscal year 2005 budget.

Moreover, the fiscal year 2005 budget contains advanced planning funds for site selection and preliminary activities to serve veterans in six new national cemeteries: Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota, Florida.

With the opening of these new national cemeteries and state veterans' cemeteries over the next four years, the percentage of veterans served by burial option within 75 miles of their residence will rise to 83 percent in 2005 from a level of 73 percent in 2001. The completion of these new cemeteries will represent an 85 percent expansion of the number of gravesites available in the national cemetery system since 2001, almost doubling the number of gravesites during this period.

Expanding cemetery capacity is coincident with projections of expanding numbers of veteran deaths and interments performed by the NCA. With the aging of World War II and Korean War veterans, nearly 655,000 veteran deaths are estimated in 2005 with the death rate increasing annually and peaking at 676,000 in 2009. It is expected that one of every six of these veterans will request burial in a national cemetery.

As the volume and intensity of cemetery operations increase, NCA staffing needs become more critical. While *The Independent Budget* veterans service organizations (IBVSOs) support efforts to increase efficiency of operations, it is essential to remember that much NCA work is labor-intensive, requiring a fully staffed and fully equipped workforce.

In addition to NCA staffing requirements, the visual appearance of national cemeteries as shrines is another NCA high priority. Many individual cemeteries are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of our country. With this understanding, the national cemetery system represents a unique treasure that deserves to be protected and nurtured.

Unfortunately, despite continued high standards of service and despite a true need to protect and nurture this national treasure, the NCA system continues to face a serious challenge in improving the appearance of cemetery assets.

The Independent Budget for Fiscal Year 2006 recommends an operations budget of \$200 million for the NCA to meet increasing demands for service, heightened gravesite maintenance, a nationwide shrine initiative, and other essential related areas of cemetery operations.



NCA ACCOUNT

The National Cemetery Administration (NCA) is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

As the veterans' population ages, demand for NCA services will remain high. In recent years, the NCA burial rate has averaged more than 90,000 interments per year. According to Department of Veterans Affairs' (VA) projections, annual individual burials will peak in 2008. Clearly, NCA resources must keep pace in order to meet the growing workload of increasing demands of interments, gravesite maintenance, cemetery repairs, general upkeep, and related labor-intensive requirements of cemetery operations.

The NCA also faces a challenge of completing a work schedule that attends to the repair and renovation needs of more than 900 projects identified in volume 2 of *An Independent Study on Improvements to Veterans Cemeteries*, a review of current and future burial needs submitted to Congress by VA in 2001. According to the study, these project recommendations, which have an estimated cost of \$279 million, recognized existing, deteriorating conditions at individual cemeteries in the NCA portfolio.

If the National Cemetery Administration is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries.

To fulfill a national commitment to maintain national cemeteries as national shrines, *The Independent Budget* veterans service organizations (IBVSOs) recommend Congress establish a five-year, \$250 million program to restore and improve the condition and character of NCA cemeteries as part of this year's operations budget.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service.

The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries, who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

Under the Presidential Memorial Certificate program, the award of a certificate, signed by the president, is in addition to the provision of the United States flag, furnished by VA to all veterans honorably discharged from military service or otherwise eligible for burial in a national cemetery.

In whole, *The Independent Budget* recommends an operations budget of slightly more than \$200 million for the NCA to meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

Congress should provide \$200 million for fiscal year 2006 to offset the higher costs related to increased workload, additional staff needs, general inflation and wage increases, and an enhanced national shrine initiative.

Congress should include as part of the NCA appropriation, \$50 million for the first stage of a \$250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

National Cemetery Administration (in thousands)

FY 2005	\$147,734
FY 2006 Administration Request	167,409
FY 2006 <i>Independent Budget</i> Recommendation	204,046

FY 2006 Recommendation (in thousands)

Current Services Estimate	\$154,046
Shrine Initiative.....	50,000
Total, FY 2006 Recommendation.....	\$204,046

NCA ISSUES

The National Cemetery Administration is faced with a number of serious challenges. One of the most serious of these, described previously, is the provision of adequate funding to meet increasing demands of interments, gravesite maintenance, repairs, upkeep, and related labor-intensive requirements of cemetery operations. Another major challenge facing the NCA is to ensure that all national cemeteries are maintained in a manner appropriate to their status as national shrines and memorials of reverence. In addition, the State Cemeteries Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. Moreover, Congress faces the challenge of stemming the serious erosion in the value of burial allowance benefits. *The Independent Budget* veterans service organizations have identified these issues as critical to ensuring world-class, quality service delivery from the NCA and integral to the memory of all veterans who have served their Country honorably and faithfully.

State Cemeteries Grant Program:

Heightened interest in the State Cemeteries Grant Program (SCGP) results in stronger state participation and increased demands on the program.

The State Cemetery Grants Program (SCGP) complements the National Cemetery Administration (NCA) mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries.

The SCGP makes burial options more available, more accessible, and more convenient. Since 1973, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The SCGP provides funds to assist states in establishing, expanding, and improving state-owned cemeteries. The program has helped develop 56 operating cemeteries across the country which accounted for 19,246 burials of veterans and their eligible family members in fiscal year 2004 (FY 2004), an increase of nearly 5.6 percent over the prior year.

In FY 2004, the state cemetery grant program awarded \$39.8 million. Currently six new cemeteries are under construction: Boise, Idaho (the last state in the nation without a veterans' cemetery); Wakeeney, Kansas (300 miles east of Denver and west of Kansas City, serving rural area in western Kansas); Winchendon, Massachusetts (serves densely populated northern Massachusetts); Killeen (Ft. Hood), Texas; and

Suffolk, Virginia (serves 200,000 veterans in the Tidewater area).

The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

States remain, as before enactment of the Veterans Benefits Improvements Act of 1998, totally responsible for operations and maintenance, including additional equipment needs following the initial federal purchase of equipment. The program allows states in concert with the NCA to plan, design, and construct top-notch, first-class, quality cemeteries to honor veterans.

Recommendations:

Congress should fund the SCGP at a level of \$37 million and encourage continued state participation in the program.

Congress should recognize the increased program interest by the states and provide adequate funding to meet planning, design, construction, and equipment expenses.

The NCA should continue to effectively market the SCGP.

Veterans Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

A PricewaterhouseCoopers study, submitted to the Department of Veterans Affairs (VA) in December 2000, indicates serious erosion in the value of burial allowance benefits. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when the federal government first started paying burial benefits for our veterans.

In the 107th Congress, the plot allowance, limited to wartime veterans, was increased for the first time in more than 28 years, to \$300 from \$150, approximately 6 percent of funeral costs. *The Independent Budget* veterans service organizations (IBVSOs) recommend increasing the plot allowance from \$300 to \$745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery—not just those who served during wartime.

Also, in the last Congress, the allowance for service-connected deaths was increased \$500 to \$2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance was raised to make a more meaningful contribution to the costs of burial for our veterans. The IBVSOs recommend increasing the service-connected benefit from \$2,000

to \$4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6 percent of funeral costs. We recommend increasing the nonservice-connected benefit from \$300 to \$1,270, bringing it back up to the original 22 percent level. Finally, the IBVSOs recognize the need to adjust burial benefits for inflation annually to maintain the value of these important benefits.

Recommendations:

Congress should increase the plot allowance from \$300 to \$745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from \$2,000 to \$4,100.

Congress should increase the nonservice-connected benefit from \$300 to \$1,270.

Congress should enact legislation to adjust these burial benefits for inflation annually.



Strategic Planning and Performance Goals:

The strategic planning process for the National Cemetery Administration (NCA) requires meeting the increasing demands for burials and maintaining existing cemeteries to high standards.

The Veterans Millennium Health Care and Benefits Act (P.L. 106-117) required the Department of Veterans Affairs (VA) to contract for an assessment of the current and future burial needs of our nation's veterans. *An Independent Study on Improvements to Veterans Cemeteries* was submitted to Congress in 2002. Three volumes comprised the study: *Volume 1: Future Burial Needs*; *Volume 2: National Shrine Commitment*; and *Volume 3: Cemetery Standards of Appearance*. In whole,

the completed study would help form the platform for adopting further improvements to veterans cemeteries.

Volume 1: Future Burial Needs identifies those areas in the United States with the greatest concentration of veterans whose burial needs are not served by a national cemetery. According to the report, current and planned cemeteries under the National Cemetery Administration fiscal year 2000 strategic plan, which

runs through 2006, will service most large population centers. However, the report states that an additional 22 cemeteries will be required to ensure that 90 percent of veterans live within 75 miles of a national cemetery.

The Independent Budget veterans service organizations (IBVSOs) encourage Congress and the Administration to carefully consider the report's findings in achieving burial service objectives. The analysis provides useful guidelines to continue a strong state grant program, to expand existing cemeteries wherever appropriate, and to build new national cemeteries at or near densely populated areas of veterans. Without the strong commitment of Congress and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

Volume 2: National Shrine Commitment provides a systemwide comprehensive review of the conditions at 119 national cemeteries. *Volume 2* identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The total estimated cost of completing these projects is nearly \$280 million, according to the study.

The IBVSOs agree with this assessment and believe that Congress needs to address the condition of NCA cemeteries and ensure they remain respectful settings for visitors and deceased veterans. The operations budget and minor construction budget recommended by *The Independent Budget* contain funding to begin these projects based on the severity of the problems.

Volume 3: Cemetery Standards of Appearance is a careful presentation of the scope of work required to elevate existing national cemeteries as national shrines. *Volume 3* serves as a planning tool to review and refine overall operations in order to express the appreciation and respect of a grateful nation for the service and sacrifice of military veterans.

Volume 3 describes one of the most important elements of veterans' cemeteries, namely to honor the memory of America's brave men and women who served in the

armed forces. "The commitment of the nation," the report finds, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual."

The IBVSOs agree with this assessment. The purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history; the monuments, markers, grounds and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Indeed, Congress formally recognized veterans' cemeteries as national shrines in 1973, stating, "All national and other veterans cemeteries...shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43).

In this vein, the IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully. The current and future needs of the NCA require continued adequate funding to ensure that the NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the nation.

An Independent Study on Improvements to Veterans Cemeteries presents valuable information and tools for the development of a truly national veterans' cemetery system. We recommend Congress give it close examination because the suggestions it contains require congressional and administrative budgetary support.

As we look forward to funding decisions for fiscal year 2006, the IBVSOs await congressional action on appropriating funds for construction of recommended cemeteries in areas already approved for new sites. Because the planning and construction horizons of new cemeteries can take up to 10 years or more, it is important that the system develop concrete plans to address the increased demand for burial benefits in subsequent fiscal years.

Recommendations:

Congress and the Administration use *An Independent Study on Improvements to Veterans Cemeteries* to help form the platform for adopting improvements to veterans' cemeteries and for setting the course to meet increasing burial demand.

Congress should make funds available to ensure the proper planning and fast-track construction of needed

national cemeteries. Adequate funding must be ensured to complete construction of additional national cemeteries in areas that remain unserved.

Congress and the Administration must find ways to expand the useful life of currently operating national cemeteries, build new cemeteries where appropriate, and encourage state grant program cemeteries as a means of providing service to veterans.



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February 22, 2005

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For God and Country

Honorable Steve Buyer, Chairman
 Committee on Veterans' Affairs
 U.S. House of Representatives
 335 Cannon House Office Building
 Washington, DC 20515

Dear Mr. Chairman:

In response to your request to provide the House Veterans' Affairs Committee with the details and descriptions of the methodology used to develop The American Legion's Department of Veterans' Affairs (VA) Fiscal Year 2006 funding recommendation of \$34.1 billion for veterans' health care, I submit the following description of the assumptions used to project the resources that will be required to provide care to those veterans who are expected to use the VA health care system. The American Legion hopes you will find the information provided informative and useful in restoring the budgetary shortfall in the President's budget request.

Traditionally, we start with Office of Management and Budget's (OMB's) "spring guidance" to all Federal budget offices. For the most part, this "guidance" is budget-driven rather than needs based, especially with regard to VA. This guidance came well before the final VA appropriations were made for fiscal year 2005. As an example, the May 2004 "guidance" provided the following recommendations for the fiscal year 2005 request:

- Medical Care Collections Fund -- \$281 million through enrollment fees (increase \$13 million).
- Medical Care Collections Fund -- \$145 million through increased first party collections (increase of \$7 million).
- Medical Care Collections Fund -- \$9 million through long-term care collections (freeze).
- Medical Care Collections Fund -- \$1.089 billion through other third-party collections (increase of \$52 million).
- Medical and Prosthetic Research -- \$750 million (decrease \$20 million).
- Medical Care -- \$28.745 billion (decrease \$726 million).

We also consider VA's Office of the Assistant Secretary for Management's fiscal year 2005 Budget Submission as well. This publication provides a thorough overview of the entire VA budget. Although this document fails to reflect the "true" budgetary needs of VA and we disagree with many of VA legislative initiatives contained therein, it provides an alternative perspective when developing the budget recommendations submitted by The American Legion.

Honorable Steve Buyer, Chairman
February 22, 2005
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The prior fiscal year final budget approved by Congress is also taken into consideration. Due to the fact that in recent years, the final budget is not determined until late into the next fiscal year, this is becoming more difficult to use and a less reliable resource.

The American Legion collects a great deal of information through visits to VA health care facilities and first hand accounts from VA personnel and VA patients as well. We have shared much of this information with VA and Congress through congressional testimony, as well as our Annual assessment of VA- *A System Worth Saving: A Special Report on the Condition of VA Health Care in America*.

Additionally, many of The American Legion staff and volunteers serve on government advisory committees. Through these efforts, we gain tremendous insight and information on the needs of VA -- officially and unofficially. An excellent example is the service of The American Legion's National Adjutant, Robert W. Spanogle, who served as a Commissioner on the *President's Task Force to Improve Health Care Delivery for Our Nation's Veterans*. His involvement in this Committee provided insight into the improvements needed within the VA health care system.

The American Legion's assumptions and recommendations are based on the qualitative and quantitative information collected from these many official and unofficial sources.

For Fiscal Year 2005, following a continuing resolution, VA received an appropriation of \$29.98 billion. In our fiscal year 2005 budget request, The American Legion proposed \$30 billion; the Administration's request was \$26.7 billion. Both requests were exclusive of collections.

This year, The American Legion applied the highest of the past five-year Bureau of Labor Statistics' medical inflation rates of 5.0 percent (2002) to the fiscal year 2005 recommendation, then added the projected \$2.16 billion in third-party collections. Given VA's track record at collections, we then added an additional \$150 million to arrive at the \$34.1 billion we proposed to the Committee last week.

I hope I have addressed all of your concerns and as always, we look forward to working with you and your staff in the best interest of America's veterans and their families.

With warmest regards and on behalf of The American Legion, I am Sincerely Yours,



Peter S. Gaytan, Director
Veterans Affairs and
Rehabilitation Commission

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

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Methodology Used in Creation of *Independent Budget* Recommendations

Generally, for *Independent Budget* recommendations, we take the amount of the current year appropriation (in this case FY 2005) and add to each account assumptions regarding inflation and wage and salary increases in order to arrive at a current services estimate for the upcoming year (in this case FY 2006). This current services estimate uses budget object classifications to more accurately tailor percentage increases. A current services estimate merely provides a snapshot of what resources are needed in the upcoming year to meet the same needs as the current year. In certain accounts we have estimated to the best of our ability additional costs attributable to specific *Independent Budget* recommendations in order to arrive at the *Independent Budget* recommended amount. In certain VBA subaccounts included within the GOE account, we have taken a three-year average of reimbursable amounts and subtracted these from initial inflated amounts in order to come up with a "current services" estimate. For Medical Care, the *Independent Budget* estimates for Medical Administration and Medical Facilities accounts are the current services estimates; for Medical Services, estimates for the enrollment of Priority 8 veterans, increased demand, and an additional amount for specialized services and programs were added to the current services estimate in order to arrive at the *Independent Budget* recommended amount. All *Independent Budget* recommendations are for appropriated dollars only.

For the FY 2006 *Independent Budget*, in the area of wage and salary increases, we have taken the current year increase of 4.5 percent, and annualized this amount with the estimated FY 2006 increase of 3.5 percent. This amount is slightly higher than the Administration's estimate of 3.1 percent for "Federal pay raises, military" contained in the Economic Assumptions Table in the Analytical Perspectives volume of the FY 2006 budget submission. This same volume for FY 2005 estimated this increase at 4.15 percent, which underestimated the FY 2005 amount by .35 percent. It is necessary to annualize this increase due to the operation of the fiscal year as compared to the calendar year. Since FY 2006 will contain one fewer compensable day than FY 2005 (as noted in OMB Circular A-11 (2004) Section 32-5), we have also subtracted a suitable percentage from this annualized percentage amount to reflect this (FY 2006 contains a total number of compensable hours of 2,080 as compared to a FY 2005 total of 2,088, necessitating a decrease of .38 percent). For *Independent Budget* recommendations calling for increased FTE, we have taken average compensation amounts listed in the current year (FY 2005) budget submission, increased by the wage and salary percentage increase, and multiplied this average by the number of proposed FTE. Although this method perhaps under-estimates these costs, it provides us with a rough estimate in order to cost various recommendations.

As for general inflation, we have estimated a 3.5 percent increase over the course of the fiscal year, and for medical inflation a 5.2 percent increase. The general inflation estimate is slightly higher than the percentage increase in Consumer Price Index –All Urban (CPI-U) over the course of the last twelve months as reported by the Bureau of Labor Statistics on January 19, 2005. This amount is listed as 3.3 percent, for the twelve-month period ending December, 2004. The Administration has estimated a 2.3 percent increase for calendar-year 2006 (see the Economic Assumptions Table in the Analytical

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Perspectives volume of the FY 2006 budget submission). It should be noted that in its 2005 budget submission, the Administration estimated the 2004 calendar-year rate of inflation at 1.4 percent, nearly 2 percentage points lower than the percentage increase as reported by the Bureau of Labor Statistics. The slight increase over the 2004 percentage change represents concerns over the effect of energy costs and dollar valuation over the course of FY 2006. The medical inflation estimate reflects increasing percentage increases over the last two years and the absence of any macroeconomic or microeconomic rationale to slow or reverse this trend.

As you can see, *The Independent Budget* recommendations are indeed conservative estimates, and do not even begin to address the impact of previous budgetary shortfalls on the VHA. If these shortfalls were to be addressed, the *Independent Budget* recommendation would be substantially higher.



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